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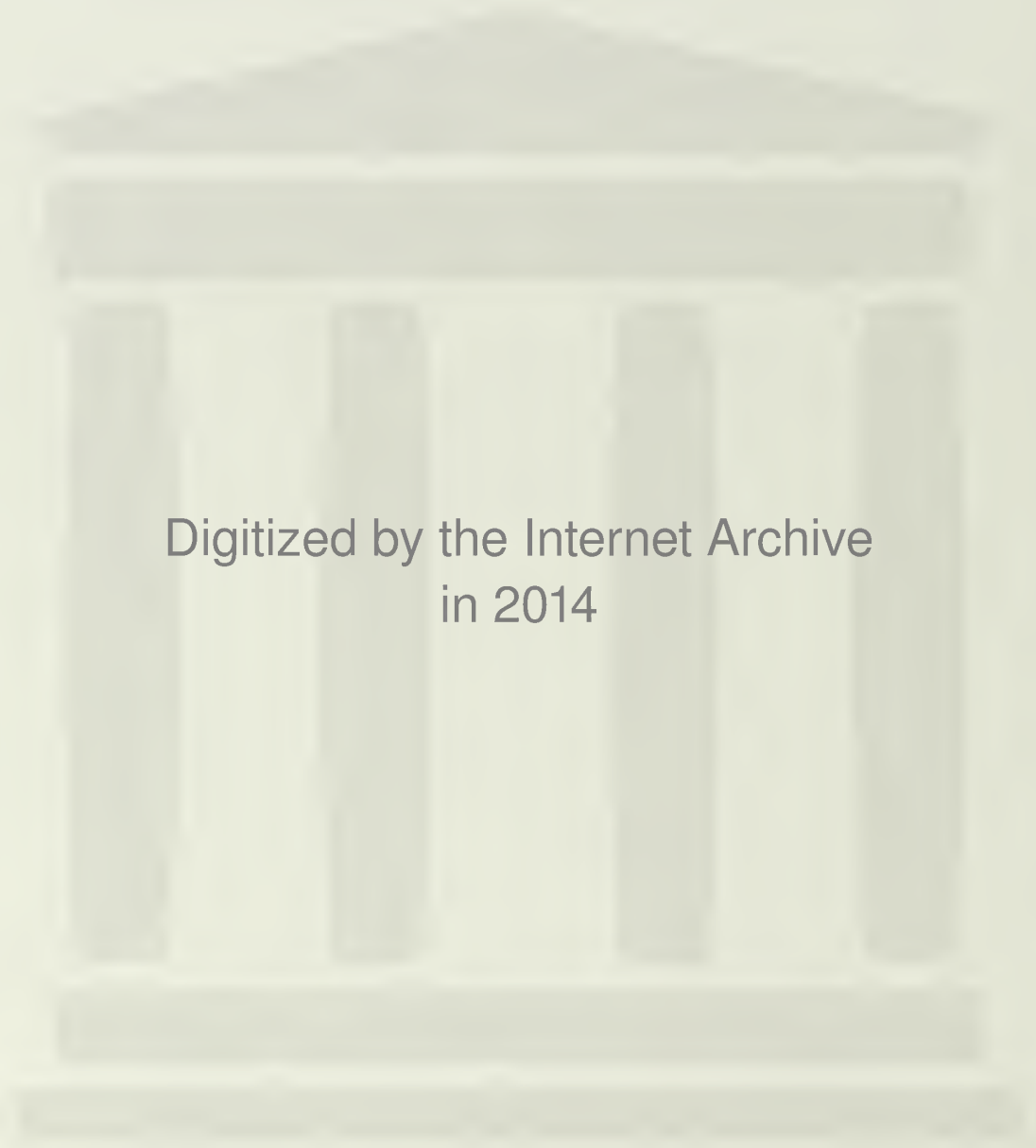
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106 CMR 435.000: MEDICAL ASSISTANCE PROGRAM: CHRONIC DISEASE AND REHABILITATION HOSPITAL SERVICES

106 CMR 453.000 is superseded by a new chapter 106 CMR 435.000:

Section

(106 CMR 435.001 through 435.400 Reserved)
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(106 CMR 435.001 through 435.400 Reserved)

435.401: Introduction

This Chapter 435.000 contains regulations governing participation in the Massachusetts Medical Assistance Program by chronic disease and rehabilitation hospitals or units within hospitals performing these services. The word "hospital" in these regulations refers specifically to a chronic disease and rehabilitation hospital or unit only, unless the context clearly indicates otherwise.

435.402: Definitions

The following terms used in these regulations shall have the meanings given in this section unless the context clearly requires a different meaning.

(A) Administrative Day -- a day of inpatient hospitalization on which a lower-than-hospital level of care is determined appropriate by the Department or its agent, but on which an appropriate placement is not available.

(B) Agent -- the Professional Standards Review Organization (PSRO) coordinator, the hospital's utilization review coordinator, or other party designated by the Department to act on its behalf in instances when the Department itself does not perform the required function.

(C) Child Abuse -- a nonaccidental physical injury to a child inflicted by another person that causes or creates a substantial risk of death or protracted impairment of any bodily organ or function; or the commission of sex offenses against a child, as defined in the criminal laws of Massachusetts.

(D) Child Neglect -- failure by a financially able caretaker responsible for a child to provide adequate food, clothing, shelter, education, medical care, proper supervision, or guardianship that results in the child's present avoidable suffering. The caretaker shall be considered capable of providing adequate food, clothing, shelter, education, medical care, proper supervision, and guardianship if he is financially able to do so or is offered other reasonable means to do so.

(E) Chronic Disease Hospital -- a facility or a unit within a facility devoted to the care and treatment of patients whose condition is expected to continue for an extended period and requires at least weekly physician visits in addition to

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(E) Chronic Disease Hospital -- a facility or a unit within a facility devoted to the care and treatment of patients whose condition is expected to continue for an extended period and requires at least weekly physician visits in addition to

skilled nursing and regular intervention by therapists and technicians.

(F) Day of Discharge -- the day on which a recipient leaves the hospital, regardless of the hour. The day of death is also considered the day of discharge.

(G) Discharge Planner -- a registered nurse or a social worker either licensed or eligible for and in the process of applying for licensure by the state of Massachusetts whose primary responsibility is discharge planning.

(H) Discharge Planning -- the coordinated effort of the discharge-planning staff of a hospital to locate appropriate placement for recipients who no longer require hospitalization.

(I) Leave-of-Absence Days -- days during which a bed in a hospital is reserved for a recipient who leaves the facility and for whom no formal discharge and readmission procedures occur.

(J) Reasonable Distance -- generally, 25 miles from the home or usual noninstitutional residence of the recipient. This definition does not preclude longer distances in such instances as, but not limited to, rural areas or in cases where the recipient has no family or regular visitors.

(K) Rehabilitation Hospital -- a facility or unit within a facility devoted to the provision of comprehensive services to patients primarily with physical handicaps, although coordinated with efforts to minimize the patient's mental, social, and vocational disadvantages. The course of treatment is limited to the period in which the recipient continues to make progress toward his treatment goal, as described in the recipient's service plan.

435.403: Eligible Recipients

(A) Medical Assistance Recipients. The Department pays for chronic disease and rehabilitation hospital services provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) subject to the restrictions and limitations described in this Chapter 435.000.

(B) General Relief Recipients. The Department does not pay for hospital services provided to General Relief recipients (category of assistance 04) except for the life-sustaining drugs listed in the Department's pharmacy regulations.

435.404: Provider Eligibility

Payment for the services described in this Chapter 435.000 will be made only to chronic disease and rehabilitation hospitals participating in the Medical Assistance Program as of the date of service.

(A) In State. To participate in the Medical Assistance Program, a chronic disease or rehabilitation hospital located in Massachusetts must:

(1) be licensed or operated by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health as a chronic disease or rehabilitation hospital or unit;

(2) have a per diem (all-inclusive payment) rate established by the Massachusetts Rate Setting Commission; and

(3) participate in the Medicare program.

(B) Out of State.

(1) Out-of-state chronic disease or rehabilitation hospitalization is reimbursable on a prior authorization basis only. The Department will consider a prior authorization request submitted by an out-of-state chronic disease or rehabilitation hospital only under the following circumstances.

(a) The hospital is located in Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont, is within 50 miles of the Massachusetts border, and provides services to a recipient who resides in a Massachusetts community near the border of that state.

(b) The hospital provides services to a recipient who is authorized to reside out of state by the Massachusetts Department of Social Services.

(c) The hospital provides services to a recipient that are not available from comparable resources in Massachusetts, that are generally acceptable medical practice, and that can be expected to benefit the recipient significantly.

(2) To participate in the Massachusetts Medical Assistance Program, an out-of-state chronic disease or rehabilitation hospital must obtain a Massachusetts Medical Assistance provider number and meet the following criteria:

(a) be approved as a chronic disease or rehabilitation

hospital by the governing or licensing agency in its state;
(b) participate in the Medicare program; and
(c) participate in that state's Medical Assistance Program (or equivalent).

(3) Payment to an out-of-state hospital will be made in accordance with the Medical Assistance Program (or equivalent) fee schedule of that state.

435.405: Per Diem Rates

(A) The hospital per diem rate, an all-inclusive rate established by the Massachusetts Rate Setting Commission, must be accepted by the hospital as payment in full for all inpatient hospital days of care on which a hospital level of care is determined to be appropriate, in accordance with Section 435.411.

(B) The administrative day per diem rate for recipients requiring a skilled nursing facility (SNF) level of care, an all-inclusive rate established by the Rate Setting Commission, must be accepted by the hospital as payment in full for all administrative days for recipients for whom a SNF level of care is determined to be appropriate, in accordance with Section 435.411.

(C) The administrative day per diem rate for recipients requiring an intermediate care facility (ICF) level of care, an all-inclusive rate established by the Rate Setting Commission, must be accepted by the hospital as payment in full for all administrative days for recipients for whom an ICF level of care is determined to be appropriate, in accordance with Section 435.411.

435.406: Billing Exceptions to the Per Diem Rate

(A) The hospital may bill separately for those drugs and durable medical equipment that cannot be obtained from pharmacies or suppliers of durable medical equipment available to the recipient and are prescribed for take-home use. The charges for such drugs and durable medical equipment are to be submitted on the claim form specified in the billing instructions.

(B) The hospital may contract privately with the recipient for nonmedical items that are not included in the per diem rate (for example, television, radio, or telephone).

435.407: Payment

(A) The Department will pay for a hospital stay only when the treatment is medically or administratively necessary and is reimbursable according to the regulations in this Chapter 435.000.

(B) All billing shall commence on the day of the recipient's admission, regardless of the admitting hour.

435.408: Nonreimbursable Services

(A) The cost of any treatment or testing outside the hospital is included in the per diem rate and is not reimbursable.

(B) All administrative and processing costs associated with the provision of blood and its derivatives are included in the per diem rate and are not reimbursable.

(C) If a recipient occupies a private room, the hospital will not be paid any amount for the cost of that room in excess of the per diem rate. Furthermore, the hospital shall not bill the recipient for such charges.

(D) Research or the provision of experimental procedures are not reimbursable.

(E) Leave-of-absence days taken by a recipient are not reimbursable. For the purpose of payment, these days are to be treated as discharge days and admission days. Thus, the day on which the recipient leaves the hospital to start a leave of absence is not reimbursable, regardless of the hour of discharge, while the day on which the recipient returns is reimbursable. For example, if the recipient leaves the hospital on Friday night and returns on Monday morning, Friday, Saturday, and Sunday are leave-of-absence days and are not reimbursable.

(F) Level IV (rest home) care is not reimbursable.

435.409: Level-of-Care Criteria for Chronic Disease Hospitals

The following level-of-care criteria will be used by the Department or its agent to determine the medical necessity and appropriateness of chronic disease hospital placement.

(A) In order to be considered an appropriate chronic disease hospital placement, a recipient must require nursing services seven days a week for an average of 4.5 hours daily. On

acute hospitalization in the past at least monthly and whose stay in a chronic disease hospital would preclude the necessity for the majority of these acute hospitalizations.

435.410: Level-of-Care Criteria for Rehabilitation Hospitals

The following level-of-care criteria will be used by the Department or its agent to determine the medical necessity and appropriateness of a rehabilitation hospital placement. A recipient is correctly placed in a rehabilitation hospital only when a medical need exists for an intensive rehabilitation program that includes a multidisciplinary approach to improve the recipient's ability to function as independently as possible. Factors must be present in the recipient's condition that indicate the potential for functional movement or freedom from pain; a recipient who requires therapy solely to maintain function is not considered an appropriate rehabilitation hospital patient. The rehabilitation program must:

(A) include specialized skilled nursing services, physical therapy, occupational therapy, and any other services that are necessary for the rehabilitative program (such as speech therapy or prosthetic/orthotic services);

(B) be organized and directed by a physician who is qualified in rehabilitation medicine;

(C) be designed to achieve specified goals within a given time frame; and

(D) include team conferences at which all team members are present. The first of these team conferences must occur within seven days of the recipient's admission to the hospital, and successive team conferences must occur at least every 14 days thereafter. These conferences must assess the recipient's progress, adjust rehabilitative goals when necessary, and terminate the rehabilitation program when the expected outcome is reached. A record must be maintained of each team member's goals and progress notes at each conference, and all decisions reached during these team conferences must be recorded in the recipient's medical record.

435.411: Utilization Review

(A) The hospital must determine the medical or administrative necessity and appropriateness of each inpatient hospital admission and continued stay of a recipient in accordance with the level-of-care criteria in Sections 435.409 through 435.410. For those recipients requiring a less-than-hospital

of the recipient's medical condition (for example, when the recipient has chronic obstructive pulmonary disease or pulmonary edema); and

(9) treatment of deep decubitus ulcers (deep area with or without necrotic tissue) or deep skin lesions when the physician has prescribed irrigation or the application of medication or sterile dressings. Infected skin lesions may require skilled nursing care to prevent the spread of the infection to other patients. When care of infected skin lesions is the basis for recommending or approving the need for skilled nursing care, the need must be documented in the recipient's medical record.

(B) In addition, the recipient must require, on average, treatment by a physician on a weekly basis. This physician intervention must be care that only a physician can provide, such as, but not limited to, the following:

(1) treatment given by the physician himself;

(2) changes in orders for treatments to be administered by the nursing staff;

(3) changes in orders for drugs to be administered by the nursing staff; and

(4) observations that can be made only by a physician.

The reason for the physician's visit, the observations made, and the proposed plan for continued treatment must be entered into the recipient's medical record. A diagnosis of terminal illness is not, in itself, sufficient reason for chronic disease hospitalization.

(C) The following are examples of appropriate chronic disease hospital placement:

(1) recipients who require suctioning/nasopharyngeal aspiration at least once per nursing shift or continuous use of a respirator (for example, intubation and mechanical ventilatory support);

(2) recipients with frequent life-threatening arrhythmias that require monitoring and medical intervention;

(3) recipients whose severe electrolyte derangements are difficult to control;

(4) recipients with uncontrollable epileptic seizures at a frequency of more than three times weekly as documented in their medical records;

(5) recipients with multiple medical problems who are medicated with anticoagulants, chemotherapy for neoplastic diseases, or steroids that require a physician's evaluation or a drug regimen weekly;

(6) recipients receiving parenteral solutions on a frequent and continuous basis; and

(7) recipients with medical conditions that have required

average, at least 1.5 hours of this nursing care must consist of skilled nursing services. Skilled nursing services include, but are not limited to, the following:

(1) nursing observation and care for a recipient's unstable or complex medical condition (for example, brittle diabetes or blood dyscrasia);

(2) administration of oral or injectable medications that require the judgment and direction of a registered nurse to monitor the dosage and frequency and to observe the recipient for any adverse reactions to the medication. Drugs with life-threatening side effects, given as treatment for an acute condition, may require skilled nursing care. Administration of the same drug, given in a reduced dosage as a maintenance regimen, does not, in itself, indicate the need for skilled nursing care, nor does a 24-hour medication regimen;

(3) nasopharyngeal aspiration and tracheotomy care; however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled nursing services;

(4) levin tube and gastrostomy feedings;

(5) administration of parenteral solutions on a regular and continuous basis;

(6) care of a colostomy either during an early postoperative period when related medical complications are present or when provided in combination with colostomy training. General continuous maintenance care of a colostomy can usually be performed by the patient himself or by a person without skilled training and, therefore, does not, in itself, indicate the need for skilled nursing services;

(7) care of a suprapubic catheter or care of a urethral catheter when the insertion and maintenance of the urethral catheter is part of an active treatment for a disease of the urinary tract and irrigation is required for medical reasons (for example, when a recipient has cancer of the bladder or a resistant bladder infection).

(a) When care of a urethral catheter is the basis for recommending or approving the need for skilled nursing care, the urethral catheter must be prescribed by a physician and the need for the catheter must be documented in the recipient's medical record.

(b) the presence of a urethral catheter, particularly one placed for convenience, for the control of incontinence, or for routine irrigation, does not, in itself, indicate the need for skilled nursing care.

(c) For the purposes of this subsection, a urinary tract infection caused by the use of a catheter does not constitute a disease condition;

(8) administration of oxygen or other medical gases when they are needed on a regular and continuing basis because

dition that indicate the potential for functional movement or freedom from pain; a recipient who requires therapy solely to maintain function is not considered an appropriate rehabilitation hospital patient. The rehabilitation program must:

(A) include specialized skilled nursing services, physical therapy, occupational therapy, and any other services that are necessary for the rehabilitative program (such as speech therapy or prosthetic/orthotic services);

(B) be organized and directed by a physician who is qualified in rehabilitation medicine;

(C) be designed to achieve specified goals within a given time frame; and

(D) include team conferences at which all team members are present. The first of these team conferences must occur within seven days of the recipient's admission to the hospital, and successive team conferences must occur at least every 14 days thereafter. These conferences must assess the recipient's progress, adjust rehabilitative goals when necessary, and terminate the rehabilitation program when the expected outcome is reached. A record must be maintained of each team member's goals and progress notes at each conference, and all decisions reached during these team conferences must be recorded in the recipient's medical record.

435.411: Exception to Level-of-Care Criteria

The Department recognizes one exception to the chronic disease and rehabilitation levels of care as defined in Sections 435.409 and 435.410. A recipient will be considered an appropriate chronic disease or rehabilitation hospital placement if he has a severe behavioral problem that is the result of an underlying disease process (for example, Pick's disease) and that requires more intensive management than is available in a skilled nursing facility. However, a recipient whose primary diagnosis is psychiatric is not an appropriate chronic disease or rehabilitation hospital placement.

435.412: Utilization Review

(A) The hospital must determine the medical or administrative necessity and appropriateness of each inpatient hospital admission and continued stay of a recipient in accordance with the level-of-care criteria in Sections 435.409 through 435.411. The Department will pay the hospital only at the per diem rate in Section 435.405 that corresponds to what it determines to be the appropriate level of care.

level of care, the hospital must determine the appropriate level of care in accordance with the Department's skilled nursing facility and intermediate care facility levels of care in 106 CMR 456.000. The Department will pay the hospital only at the per diem rate in Section 435.405 that corresponds to what it determines to be the appropriate level of care.

(B) The Department may designate an agent to determine the medical or administrative necessity and appropriateness of each inpatient hospital admission and continued stay. If such an agent is designated, the determination of that agent will be in lieu of the determination required in Subsection (A) above.

(C) The Department, directly or through a designated agent, will review the determinations of medical or administrative necessity and appropriateness made under Subsections (A) and (B) above. If, as a result of this review, the Department determines that an admission or continued stay was not medically or administratively necessary, or that the recipient required care at a lower level than that designated by the hospital under Subsection (A) above, the Department will recover any payments made to the hospital in excess of the appropriate per diem rate defined in Section 435.405.

435.412: Reimbursable Administrative Days

Administrative days are reimbursable when the hospital is making regular efforts to place the recipient at the appropriate level of care, is in compliance with the discharge-planning standards defined in Section 435.416, and is able to provide documentation of one of the situations defined in Subsections (A) through (G) below. Regular placement efforts will not be required for those recipients on administrative day status, defined in the regulations of the Massachusetts Department of Public Health at 105 CMR 150.003(D), whose admissions to a nursing home are restricted, unless prior approval of such placement has been issued by the Department of Public Health.

(A) Child under 18 Years of Age.

(1) The stay of a child who has suffered abuse or neglect may be reimbursable. Before determinination of administrative necessity can be made, a report of the abuse or neglect must be completed and filed according to the current regulations of the Massachusetts Department of Social Services (DSS). One copy shall be submitted to the Department or its agent at the time it is filed with DSS.

(2) When the Department or its agent verifies from an

examination of patient records that a case of lead poisoning has occurred in the child's home, the child's stay is reimbursable until the home is deleaded or other accommodations can be arranged.

(3) The stay of a child under protective custody of DSS while awaiting placement in a foster home or group care facility may be reimbursable. The hospital must provide DSS-issued documentation to the Department or its agent that the child is a DSS client.

(B) Patient Awaiting Eligibility Determination. Administrative days are reimbursable for a patient awaiting final determination of eligibility for the following categories of assistance:

Cuban Relief	(00)
Vietnamese and Cambodian Refugee	(00)
AFDC	(02)
MA/Aged	(05)
MA/AFDC	(06)
MA/Disabled	(07)
MA/under 21	(08)

Such days are reimbursable only when all of the following conditions have been met.

(1) An application for public assistance has been completed in accordance with all applicable Department regulations. Administrative days incurred prior to the filing of the completed application are not reimbursable. The hospital must show the completed application to the Department or its agent or the hospital may request the appropriate Welfare Service Office or Long-Term Care Eligibility Office to confirm to the Department's Central Office or to the agent by telephone that a final determination of eligibility is pending.

(2) The hospital's inability to transfer such a patient to another level of care must specifically result from the pending status of the patient's eligibility.

(3) At the end of the eligibility process, the Department must determine the patient eligible for assistance.

(C) Patient Awaiting SSI Eligibility Determination. Administrative days are reimbursable for a patient awaiting final determination of eligibility for the SSI/Aged (category of assistance 01) and SSI/Disabled (category of assistance 03) program of Supplemental Security Income (SSI) if all of the following conditions are met.

(1) A completed application for Supplemental Security Income must be submitted by either the patient or the hospital on behalf of the patient to the appropriate Social Security Administration office and a copy of this applica-

tion must be provided to the Department or its agent. Patients whose SSI applications have been filed prior to hospital admission must verify to the Department or its agent that the application was filed. Administrative days incurred prior to the filing of the completed SSI application are not reimbursable. The patient is responsible for completing the application according to the applicable federal regulations.

(2) The hospital's inability to transfer such a patient to another level of care must specifically result from the pending status of the patient's eligibility.

(3) At the end of the eligibility process, the Social Security Administration must determine the patient eligible for SSI.

(D) Closing or Sanctioning of Nursing Home. Administrative days are reimbursable when termination of the license or sanctioning of a nursing home creates an emergency that requires the recipient's transfer to another nursing home, but no such bed is immediately available. Such days are reimbursable only when this emergency and the lack of appropriate beds are documented in the recipient's medical record by a letter from the Commissioner of either the Massachusetts Department of Public Health or the Department of Public Welfare.

(E) Unavailability of Appropriate Placement. Administrative days are reimbursable if no placement is available at the appropriate level of care in a facility within a reasonable distance from the recipient's home. The hospital must document this lack of available beds or services in a telephone log or in the recipient's medical record, noting each facility contacted, the date of each contact, and the response by each. For those recipients on administrative day status, defined in the regulations of the Massachusetts Department of Public Health at 105 CMR 150.003(D), for whom nursing home admissions are restricted, and for whom no prior approval for placement has been issued by the Department of Public Health, the hospital must document the reason for the restriction and note the lack of prior approval in the recipient's medical record.

(F) Available Facility Refuses to Accept Recipient. Administrative days are reimbursable if a placement is available at the appropriate level of care in a facility within a reasonable distance of the recipient's home, but the facility refuses to accept the recipient. The hospital must document the facility's refusal in the recipient's medical record and notify the Department in writing of the facility's refusal.

(G) Recipient Awaiting Arrangement or Provision of Services. Administrative days are reimbursable if the recipient is awaiting the arrangement of home care or home health services and a home care or home health agency has made a commitment to provide services to the recipient. Such a commitment must be documented in the recipient's medical record to the satisfaction of the Department or its agent. If the hospital attempts to arrange for the provision of home health services for a recipient and an agency that provides such services refuses to accept the recipient as a client, the hospital must notify the Department in writing of this refusal.

435.413: Nonreimbursable Administrative Days

(A) Administrative days are not reimbursable if:
(1) a placement at the appropriate level of care is available in a facility within a reasonable distance of the recipient's usual noninstitutional residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement; or
(2) the Department determines that there is a placement available at the appropriate level of care within a reasonable distance of the recipient's usual noninstitutional residence, advises the hospital of the location of this facility, and the hospital or the physician neglects or refuses to discharge the recipient to the available placement.

(B) The provisions of Subsections (A)(1) and (2) above are not applicable to reimbursement for those recipients on administrative day status, defined in the regulations of the Massachusetts Department of Public Health at 105 CMR 150.003(D), whose admissions to nursing homes are restricted unless a prior approval of placement has been issued by the Department of Public Health.

435.414: Notification of Denial

The Department or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines that the hospital admission or continued stay, or any part thereof, is not medically or administratively necessary. The Department or its agent shall notify the hospital and the recipient's attending physician whenever it determines that the hospital stay is no longer appropriate at a chronic disease or rehabilitation hospital level of care, but is administratively necessary. The Department or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines that

Cuban Relief	(00)
Vietnamese and Cambodian Refugee	(00)
AFDC	(02)
MA/Aged	(05)
MA/AFDC	(06)
MA/Disabled	(07)
MA/under 21	(08)

Such days are reimbursable only when all of the following conditions have been met.

(1) An application for public assistance has been completed in accordance with all applicable Department regulations. Administrative days incurred prior to the filing of the completed application are not reimbursable. The hospital must show the completed application to the Department or its agent or the hospital may request the appropriate Welfare Service Office or Long-Term Care Eligibility Office to confirm to the Department's Central Office or to the agent by telephone that a final determination of eligibility is pending.

(2) The hospital's inability to transfer such a patient to another level of care must specifically result from the pending status of the patient's eligibility.

(3) At the end of the eligibility process, the Department must determine the patient eligible for assistance.

(C) Patient Awaiting SSI Eligibility Determination. Administrative days are reimbursable for a patient awaiting final determination of eligibility for the SSI/Aged (category of assistance 01) and SSI/Disabled (category of assistance 03) program of Supplemental Security Income (SSI) if all of the following conditions are met.

(1) A completed application for Supplemental Security Income must be submitted by either the patient or the hospital on behalf of the patient to the appropriate Social Security Administration office and a copy of this application must be provided to the Department or its agent. Patients whose SSI applications have been filed prior to hospital admission must verify to the Department or its agent that the application was filed. Administrative days incurred prior to the filing of the completed SSI application are not reimbursable. The patient is responsible for completing the application according to the applicable federal regulations.

(2) The hospital's inability to transfer such a patient to another level of care must specifically result from the pending status of the patient's eligibility.

(3) At the end of the eligibility process, the Social Security Administration must determine the patient eligible for SSI.

(D) Closing or Sanctioning of Nursing Home. Administrative days are reimbursable when termination of the license or sanctioning of a nursing home creates an emergency that requires the recipient's transfer to another nursing home, but no such bed is immediately available. Such days are reimbursable only when this emergency and the lack of appropriate beds are documented in the recipient's medical record by a letter from the Commissioner of either the Massachusetts Department of Public Health or the Department of Public Welfare.

(E) Unavailability of Appropriate Placement. Administrative days are reimbursable if no placement is available at the appropriate level of care in a facility within a reasonable distance from the recipient's home. The hospital must document this lack of available beds or services in a telephone log or in the recipient's medical record, noting each facility contacted, the date of each contact, and the response by each.

(F) Available Facility Refuses to Accept Recipient. Administrative days are reimbursable if a placement is available at the appropriate level of care in a facility within a reasonable distance of the recipient's home, but the facility refuses to accept the recipient. The hospital must document the facility's refusal in the recipient's medical record and notify the Department in writing of the facility's refusal.

(G) Recipient Awaiting Arrangement or Provision of Services. Administrative days are reimbursable if the recipient is awaiting the arrangement of home care or home health services and a home care or home health agency has made a commitment to provide services to the recipient. Such a commitment must be documented in the recipient's medical record to the satisfaction of the Department or its agent. If the hospital attempts to arrange for the provision of home health services for a recipient and an agency that provides such services refuses to accept the recipient as a client, the hospital must notify the Department in writing of this refusal.

435.414: Nonreimbursable Administrative Days

Administrative days are not reimbursable if:

(A) a placement at the appropriate level of care is available in a facility within a reasonable distance of the recipient's usual noninstitutional residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement; or

the hospital stay is no longer administratively necessary due to the refusal of an appropriate placement in accordance with Section 435.413.

435.415: Appeals

(A) A recipient may request a fair hearing before the Department in cases when the Department or its agent determines as the result of a review that there is no administrative necessity for a continued stay due to the availability of an appropriate placement as described in Section 435.413.

(B) A hospital may request a fair hearing before the Department when the Department or its agent determines as the result of a review that an admission or a continued stay, or any part thereof, is not medically necessary but is administratively necessary. A recipient or a hospital may request a fair hearing before the Department when the Department or its agent determines, as the result of a review, that an admission or continued stay, or any part thereof, is not medically or administratively necessary.

(C) Written notice of the right to a fair hearing and the manner in which and time within which a hearing must be requested will be provided at the time of the determination by the Department or its agent.

435.416: Discharge-Planning Standards

(A) Effective Date. The discharge-planning standards defined in this Section 435.416 will become effective one year from the effective date of this Chapter 435.000.

(B) Exemptions from Discharge-Planning Standards. A chronic disease or rehabilitation hospital will be exempted from the discharge-planning standards defined in this section if it meets one of the following criteria:

(1) the hospital has filed an application with the Determination of Need Program of the Massachusetts Department of Public Health to relicense the entire facility or a distinct unit within the facility at a skilled nursing facility or intermediate care facility level of

care, or some combination thereof; or
(2) the hospital had, for the most recent rate year, an administrative day occupancy rate of 40 percent or greater, and is able to demonstrate to the satisfaction of the Department that the implementation of the discharge-planning standards defined in this section would cause undue hardship to recipients and their families. The burden of proof of such hardship rests with the hospital, and the Department retains final authority for granting or withholding the exemption.

(C) Staff.
(1) The hospital must assign in writing the responsibility for all patient discharge planning to one appropriate department (such as social services or continuing care). That department in turn must designate specific staff members whose primary duties are discharge planning.
(2) The discharge-planning staff must include either a registered nurse or a social worker who is licensed or eligible and applying for licensure in Massachusetts, and is under the supervision of, or in consultation with, a licensed graduate-level nurse or social worker.
(3) Unless permitted a lower ratio by the Department, the hospital must employ one discharge planner or full-time equivalent for every 60 licensed beds. Visiting Nurse Association (VNA) or home health staff who are not employed by the hospital, but who regularly perform discharge-planning activities there, may be included in this ratio.
(4) The hospital must demonstrate to the Department that it provides formal inservice training programs and regular case conferences for all discharge-planning staff and all other personnel who affect the discharge-planning process.

(D) Operations and Procedures.
(1) The discharge-planning staff must maintain a daily updated, chronological list of all recipients on administrative day status. The list must contain the date administrative day status commenced and the recommended level of care upon discharge. The discharge-planning department must use this chronological list to ensure that recipients who have spent the longest time on administrative day status receive priority in placement attempts.
(2) The discharge-planning department must maintain up-to-date lists of the following:
(a) all licensed nursing homes within a 25-mile minimum radius of the hospital. This list must show the number of beds, the levels of care for which the facility is licensed, whether the facility is Medicare certified,

and any other notable characteristics (for example, availability of bilingual staff). The list must also contain the name of the individual at that institution responsible for admissions; and

(b) all community-based organizations and resources within a 25-mile minimum radius of the hospital that provide services and support to recipients discharged to the community. Such resources include housing for the elderly, home health agencies, homemaker services, transportation services, friendly visitor programs, and meal programs.

(3) As a routine practice, admissions data, including but not limited to age and diagnosis, must be screened by discharge-planning staff within 24 hours of admission in accordance with written criteria that identify pertinent patient characteristics and any high-risk diagnoses. Discharge-planning activities must then commence within 72 working hours of admission for every recipient expected to require posthospital care or services.

(4) The hospital must have a written policy that allows discharge-planning staff access to all recipients and their medical records. If such access is medically contra-indicated, the recipient's physician must sign a statement specifying the reason for the contraindication and the hospital must maintain the statement in the recipient's medical or discharge-planning record.

(5) The discharge-planning staff and the primary-care team must coordinate and document in writing a plan for each recipient who requires posthospital care that specifies the services or care expected to be required by the recipient, the frequency, intensity, and duration of such services, and the resources available to provide the care or services, including available family and community support. The plan must be updated if the recipient's condition changes significantly. If an institutional placement is recommended upon the recipient's discharge, the plan must state why available community resources are inadequate to meet the recipient's needs.

(6) Each visit to a recipient by a member of the discharge-planning staff must be noted in the recipient's discharge-planning record. The notation must include the date of the meeting, any discharge options discussed, any particular problems noted, any agreements reached with the recipient, and the future activities of the discharge-planning staff that address the problems raised or that continue preparation of the recipient for discharge.

(7) Whenever possible, the discharge-planning staff or primary-care team must contact the recipient's family to encourage its involvement in planning the recipient's

discharge. To this end, family members must be informed of the discharge options and community resources available to the recipient and provided with lists of nursing homes and community resources in the area. When possible, these meetings or telephone consultations with the family must be held once every two weeks until the recipient is discharged. The dates of these meetings and other family contacts, items discussed, problems identified, and agreements reached must be entered on the recipient's discharge-planning record.

(8) The hospital must have written procedures for arranging posthospital services for recipients. At a minimum, these procedures must include frequent, systematic contacts (usually, three times weekly) by telephone or person to all nursing homes and community-service providers within a 25-mile minimum radius of the hospital in order to:

(a) determine what services at that location are or will soon become available and to ensure that the provider has current information, including medical and psychosocial status, on any recipient now or soon needing placement; and

(b) arrange for placement or services or both for recipients awaiting discharge. These recipient-specific contacts must be documented as to their number, frequency, and outcome, and must be made by a registered nurse or by a social worker who is licensed or eligible and applying for licensure in Massachusetts. The only exception in which such a call may be made by another person is when that person regularly works in the discharge-planning department, has received training in patient placement from a discharge planner, and consults all the relevant discharge documentation for the recipient when making the call. If, during the call, a question is asked that cannot be answered from the written data, it must be referred to a discharge planner.

(E) Level of Care.

(1) The recipient's physician and a registered nurse must determine the level of care required by a recipient upon discharge in accordance with the Department's level-of-care criteria for nursing homes. Both the recipient's medical and discharge-planning records must include the specific factors that indicate the recommended level of care and the names of the persons who determined it.

(2) For any recipient on administrative day status, the level-of-care recommendation must be reassessed at least once every 30 days and whenever a significant change occurs in the recipient's medical or psychosocial condition. The

date of each reassessment and the name of the person or persons making the reassessment must be noted in both the recipient's medical and discharge-planning records.

(F) Cooperation with Case Management Screening Program (CMSP). In areas of the state where the Department operates a Case Management Screening Program (CMSP), the hospital must forward all required documentation on recipients to be discharged to the CMSP placement team and request a level-of-care approval as soon as a level-of-care determination is made. The hospital must also seek the assistance of the CMSP placement team in finding placements for recipients on administrative day status and must allow the CMSP staff access to recipients on administrative day status.

(G) Reporting Discrimination Against Recipients. The hospital must have a formal written policy for the discharge-planning staff to use when reporting to the Department all suspected cases of discrimination against recipients by Medical Assistance providers.

(H) Disclosure Requirements. All written procedures and policies, lists, review criteria, discharge plans, and records used by the discharge-planning department in performing its duties must be made available for inspection by the Department.

case conferences for all discharge-planning staff and all other personnel who affect the discharge-planning process.

(B) Operations and Procedures.

(1) The discharge-planning staff must maintain a daily updated, chronological list of all recipients on administrative day status. The list must contain the date administrative day status commenced and the recommended level of care upon discharge. The discharge-planning department must use this chronological list to ensure that recipients who have spent the longest time on administrative day status receive priority in placement attempts.

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(3) As a routine practice, admissions data, including but not limited to age and diagnosis, must be screened by discharge-planning staff within 24 hours of admission in accordance with written criteria that identify pertinent patient characteristics and any high-risk diagnoses. Discharge-planning activities must then commence within 72 working hours of admission for every recipient expected to require posthospital care or services.

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(6) Each visit to a recipient by a member of the discharge-planning staff must be noted in the recipient's discharge-planning record. The notation must include the date of the meeting, any discharge options discussed, any particular problems noted, any agreements reached with the recipient, and the future activities of the discharge-planning staff that address the problems raised or that continue preparation of the recipient for discharge.

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patient placement from a discharge planner, and consults all the relevant discharge documentation for the recipient when making the call. If, during the call, a question is asked that cannot be answered from the written data, it must be referred to a discharge planner.

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(2) For any recipient on administrative day status, the level-of-care recommendation must be reassessed at least once every 30 days and whenever a significant change occurs in the recipient's medical or psychosocial condition. The date of each reassessment and the name of the person or persons making the reassessment must be noted in both the recipient's medical and discharge-planning records.

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(E) Reporting Discrimination Against Recipients. The hospital must have a formal written policy for the discharge-planning staff to use when reporting to the Department all suspected cases of discrimination against recipients by Medical Assistance providers.

(F) Disclosure Requirements. All written procedures and policies, lists, review criteria, discharge plans, and records used by the discharge-planning department in performing its duties must be made available for inspection by the Department.

Department of Public Welfare

Medical Assistance Program

Administrative and

Billing Regualtions

The Commonwealth of Massachusetts Department of Public Welfare.....

106 CMR 450.000: MEDICAL ASSISTANCE PROGRAM: ADMINISTRATIVE AND BILLING REGULATIONS

106 CMR 450.000 is amended by striking out all of the sections contained therein and inserting in their place the following sections:

Section

(106 CMR 450.001 through 450.100 Reserved)
450.101 Definitions
450.102 Purpose of 106 CMR Chapters 400 through 499
450.103 Promulgation of Regulations
450.104 Legal Bases of the Medical Assistance and General Relief Medical Assistance Programs
450.105 Categories of Assistance
450.106 Eligible Recipients
450.107 Reimbursable Medical Services
(106 CMR 450.108 through 450.200 Reserved)
450.201 Choice of Provider
450.202 Discrimination
450.203 Payment in Full
450.204 Medical Standards
450.205 Recordkeeping and Disclosure
450.206 Determination of Compliance with Medical Standards
(106 CMR 450.207 through 450.210 Reserved)
450.211 Provider Eligibility: Eligibility Criteria
450.212 Provider Eligibility: Termination of Participation for Ineligibility
450.213 Provider Eligibility: Suspension of Participation Pursuant to U.S. Department of Health, Education and Welfare Order
450.214 Provider Eligibility: Notification of Potential Changes in Eligibility
450.215 Provider Eligibility: Limitations on Participation pending Eligibility Decision or Status Change
450.216 Provider Eligibility: Ineligibility of Suspended Providers
(106 CMR 450.217 through 450.220 Reserved)
450.221 Provider Agreement: Definitions
450.222 Provider Agreement: Application for Agreement
450.223 Provider Agreement: Execution of Agreement
450.224 Provider Agreement: Ineligibility of Convicted Provider
450.225 Provider Agreement: Individual Practitioners
450.226 Provider Agreement: Issuance of Provider Numbers
450.227 Provider Agreement: Termination or Disapproval for Nondisclosure
450.228 Fiscal Agents: Disclosure of Information
(106 CMR 450.229 through 450.230 Reserved)
450.231 Limitations of Payments: Participation of Both Provider and Recipient
450.232 Limitations of Payments: Maximum Allowable Amount to In-State Providers
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450.235 Limitations of Payments: Calculation of Overpayments by Sampling
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(106 CMR 450.001 through 450.100 Reserved)

450.101: Definitions

A number of common words and expressions are specifically defined here. Whenever one of them is used in the regulations, or in a provider agreement, it will have the meaning given in the definition, unless the context clearly requires a different meaning. When appropriate, words and expressions may be defined by reference to a definition appearing in federal regulations. Words set in SOLID CAPITALS are defined elsewhere in this list.

(A) Administrative Action -- a measure taken by the DEPARTMENT to correct or prevent the recurrence of an unacceptable course of action by a PROVIDER, a RECIPIENT, or a BILLING INTERMEDIARY, including but not limited to the imposition of a SANCTION.

(B) Audit -- a DEPARTMENT examination of PROVIDER, RECIPIENT, or BILLING INTERMEDIARY practices by means of an on-site visit, a review of the DEPARTMENT'S CLAIM and payment records, a review of a PROVIDER'S medical and other documentary records such as prior authorizations and merchandise invoices, or any combination of these. Audits are conducted to ensure PROVIDER, RECIPIENT, and BILLING INTERMEDIARY compliance with laws and REGULATIONS governing the MEDICAL ASSISTANCE PROGRAM.

(C) Authorized Billing Agency -- see "BILLING AGENCY".

(D) Authorized Group Practice Organization -- see "GROUP PRACTICE".

(E) Billing Agency -- a business, other than a GROUP PRACTICE ORGANIZATION, that contracts with a PROVIDER to act as the PROVIDER'S representative in the performance of financial-management functions. A billing agency prepares and submits CLAIMS on the PROVIDER'S behalf based on information supplied by the PROVIDER, and may also provide a range of additional clerical, bookkeeping, or management-consulting services. A billing agency may also be known as a billing service or a service bureau. An AUTHORIZED BILLING AGENCY is a billing agency that is authorized by the DEPARTMENT to prepare and submit CLAIMS to the DEPARTMENT on behalf of one or more PARTICIPATING PROVIDERS.

(F) Billing Intermediary -- an individual or organization, other than an employee of a PROVIDER, that prepares and submits CLAIMS on behalf of a PROVIDER. A billing intermediary may be a BILLING AGENCY or a GROUP PRACTICE ORGANIZATION.

(G) Claim -- a request by a PROVIDER for payment for an item of MEDICAL SERVICE, identified on a claim form by RECIPIENT, date of service, and description of service provided.

(H) Claims Processing Center -- a facility designated by the DEPARTMENT to receive, review, and process CLAIMS for payments.

(I) Commissioner -- the Commissioner of Public Welfare appointed pursuant to M.G.L. c. 18, s. 3.

(J) Community Service Area (CSA) -- a geographical area containing one or more WELFARE SERVICE OFFICES at which Massachusetts residents may apply for assistance and be directed to sources of care.

(K) Contractor -- the individual or other legal entity with which the DEPARTMENT makes a contract, called a PROVIDER AGREEMENT, for the MEDICAL SERVICES of a PROVIDER. When the context permits, the term "contractor" also means the PROVIDER that is the subject of a PROVIDER AGREEMENT.

(L) Department -- the Massachusetts Department of Public Welfare organized under M.G.L. c. 18.

(M) Final Disposition -- a written response by a HEALTH INSURER to whom a request for payment has been made, such as a rejection notice, an Explanation of Benefits (EOB), or a similar letter or form, by which the insurer either denies coverage or acknowledges coverage and indicates the amount that the HEALTH INSURER will pay.

(N) General Relief Medical Assistance Program -- the program administered by the DEPARTMENT, through the MEDICAL DIVISION, that furnishes and pays for limited MEDICAL SERVICES to persons entitled to General Relief. Authority for the General Relief Medical Assistance Program has heretofore been granted in the appropriations acts of the General Court, e.g., Chapter 363(A) of the Acts of 1977, item 4406-2000; Chapter 367 of the Acts of 1978, item 4406-2000. (See Section 450.104.)

(O) Group Practice -- a group of INDIVIDUAL PRACTITIONERS who have mutually arranged, through a GROUP PRACTICE ORGANIZATION, for the joint use of facilities, equipment, and supporting personnel, and for the payment into a common account of proceeds from the delivery of MEDICAL SERVICES by members of the group, such proceeds being used and distributed to members in accordance with methods determined by the group. A legal entity that employs or contracts with one or more INDIVIDUAL PRACTITIONERS for the delivery of MEDICAL SERVICES may also be considered to be a group practice. In such cases, the INDIVIDUAL PRACTITIONERS who are employees or CONTRACTORS shall be deemed to be members of the group practice. An organization that is itself a PARTICIPATING PROVIDER, such as a licensed clinic, will not be considered a group practice.

(P) Group Practice Organization -- the legal entity that provides support services to a GROUP PRACTICE, and that manages the GROUP

PRACTICE'S finances. An AUTHORIZED GROUP PRACTICE ORGANIZATION is a group practice organization that is authorized by the DEPARTMENT to prepare and submit CLAIMS to the DEPARTMENT on behalf of the members of the GROUP PRACTICE.

(Q) Health Insurer -- an insurer or agency (including MEDICARE) that has issued a health-insurance plan or policy under which it has agreed to pay for MEDICAL SERVICES furnished to a RECIPIENT.

(R) Individual Practitioners -- physicians, dentists, licensed, registered, or certified medical practitioners, or psychologists.

(S) Medicaid -- see "MEDICAL ASSISTANCE PROGRAM".

(T) Medical Assistance Program -- the program administered by the DEPARTMENT through the MEDICAL DIVISION, pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396-1396i) and M.G.L. c. 118E to furnish and to pay for MEDICAL SERVICES to Medical Assistance RECIPIENTS.

(U) Medical Division -- the part of the DEPARTMENT that is the Medical Assistance unit established pursuant to 42 CFR 431.11.

(V) Medical Services -- medical or related care, including goods and services of any kind furnished to RECIPIENTS, the cost of which is paid or payable by the DEPARTMENT under the MEDICAL ASSISTANCE PROGRAM or, where the context permits, under the GENERAL RELIEF MEDICAL ASSISTANCE PROGRAM.

(W) Medicare -- a federally administered health-insurance program for persons eligible under the "Health Insurance for the Aged Act", Title XVIII of the Social Security Act (42 U.S.C. 1395-1395pp).

(X) Overpayment -- a payment made by the DEPARTMENT to or for the use of a PROVIDER to which the PROVIDER was not entitled under applicable federal and state laws and regulations. (See Section 450.234.)

(Y) Participant -- a PARTICIPATING PROVIDER, an AUTHORIZED BILLING AGENCY, or an AUTHORIZED GROUP PRACTICE ORGANIZATION.

(Z) Participating Provider -- see "PROVIDER".

(AA) Party in Interest -- a person with an ownership or control interest as defined in Subsection 450.221(A)(9).

(BB) Peer Review -- an evaluation of the quality, necessity, and appropriateness of MEDICAL SERVICES furnished by a PROVIDER, to determine compliance with professionally recognized standards of health

care or compliance with statutes, rules, and regulations under which the MEDICAL ASSISTANCE PROGRAM is administered.

(CC) Provider -- an individual, group, facility, agency, institution, organization, or business that furnishes MEDICAL SERVICES. A provider becomes a PARTICIPATING PROVIDER as a PROVIDER TYPE as of the effective date of a PROVIDER AGREEMENT between the DEPARTMENT and a CONTRACTOR for the services of the provider of that PROVIDER TYPE. Where the context permits, the term "provider" also means the CONTRACTOR with which the DEPARTMENT has contracted for that provider's services.

(DD) Provider Agreement -- a contract between the DEPARTMENT and a CONTRACTOR for the MEDICAL SERVICES of a PROVIDER.

(EE) Provider Type -- the classification in which a PROVIDER is or may be enrolled as a PARTICIPATING PROVIDER, which denotes and limits the kinds of MEDICAL SERVICES for which the PROVIDER may be reimbursed under the MEDICAL ASSISTANCE PROGRAM. There are provider application forms, eligibility criteria, and conditions of participation specific to each provider type.

(FF) Recipient -- a person enrolled in the MEDICAL ASSISTANCE PROGRAM or, where the context permits, in the GENERAL RELIEF MEDICAL ASSISTANCE PROGRAM.

(GG) Regulations -- regulations adopted by the DEPARTMENT, including but not limited to those set forth in Chapters 400 through 499 of Title 106 of the Code of Massachusetts Regulations (CMR).

(HH) Sanction -- an administrative penalty imposed by the DEPARTMENT pursuant to M.G.L. c. 118E, s. 19 against a PROVIDER or imposed against a BILLING INTERMEDIARY found to have violated laws or REGULATIONS governing the MEDICAL ASSISTANCE PROGRAM.

(II) Statutory Prerequisite -- any license, certificate, permit, or other requirement imposed by Massachusetts or federal law or regulation as a precondition to the practice of any profession or to the operation of any business or institution in or by which MEDICAL SERVICES are furnished. Statutory prerequisites include but are not limited to licenses required by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health, certificates issued by the several Massachusetts boards of registration, and certificates required by the Massachusetts Department of Public Safety.

(JJ) Welfare Service Office (WSO) -- a satellite office of a COMMUNITY SERVICE AREA office of the DEPARTMENT at which Massachusetts residents may apply for assistance and be directed to sources of care.

450.102: Purpose of 106 CMR Chapters 400 through 499

Chapters 400 through 499 of Title 106 of the Code of Massachusetts Regulations (CMR) contain the Department's regulations specific to the Medical Assistance Program and the General Relief Medical Assistance Program, and cover the matters formerly covered by Chapter VII of the Massachusetts Public Assistance Policy Manual (sometimes referred to as the Medical Care Plan). The Department also promulgates other regulations, and publishes other documents affecting those programs, including other chapters in Title 106 CMR, statements of policy and procedure, conditions of participation, guidelines, and other documents referenced in Title 106 CMR. In addition, the regulations in Title 106 CMR frequently refer to federal regulations, to regulations of the Massachusetts Department of Public Health and other agencies, and to rates and fee schedules established by the Massachusetts Rate Setting Commission for medical services.

450.103: Promulgation of Regulations

All regulations of the Department are promulgated in accordance with M.G.L. c. 30A, which provides for prior publication, opportunity for written comment by the public, and, in some instances, public hearings. For specific information on the process by which regulations are adopted, interested persons should examine M.G.L. c. 30A and the regulations of the Secretary of the Commonwealth. In the event of any conflict between the Department's regulations and applicable federal laws and regulations, the Department's regulations shall be construed so far as possible to make them consistent with such federal laws and regulations.

450.104: Legal Bases of the Medical Assistance and General Relief Medical Assistance Programs

(A) Medical Assistance Program.

(1) Prior to 1951, Massachusetts paid for the medical care of eligible recipients through a system of local agencies. In the fall of 1951, the federal government began assisting states in the reimbursement of providers of medical services for recipients in programs for the aged, the disabled, and children. In October 1960, with the financial participation of the federal government, Massachusetts initiated a comprehensive program of medical assistance for the aged.

(2) The Medical Assistance Program, commonly called Medicaid, was created by the Social Security Amendments of 1965 (P.L. 89-97), which added Title XIX -- "Grants to States for Medical Assistance Programs" -- to the Social Security Act (see 42 U.S.C. s. 1396 et seq.). Section 1901 of Title XIX permits yearly grants to states to help each state pay for medical services for those individuals who meet specific income and other eligibility requirements. The purpose of this cooperation between the federal and state governments is to assist those individuals who are unable to meet the costs of medical care.

(3) Massachusetts joined the national Medical Assistance Program in September 1966 by Executive Order 49 of the Governor. On November 22, 1969, the Massachusetts Medical Assistance Program was established by Chapter 800 of the Acts of 1969, which added Chapter 118E to the General Laws. Chapter 118E defines the major responsibilities of the Department in the areas of general policy and administration of the Program; determination of eligibility; provision of medical, diagnostic, preventive, and rehabilitative services; fiscal accountability; and payments to providers, consistent with federal laws and regulations.

(4) By joining the Medical Assistance Program, Massachusetts is eligible for federal reimbursement of approximately 50 percent of expenditures for most aspects of the Medical Assistance Program. For certain federally mandated portions of the Program, Massachusetts is reimbursed at a higher rate.

(B) General Relief Medical Assistance Program.

(1) Annual appropriations acts for the fiscal year in which this Chapter 450.000 of Title 106 of the Code of Massachusetts Regulations (CMR) became effective and for prior fiscal years have contained a provision to the effect that limited medical services shall be provided to General Relief recipients. (See the definition of the General Relief Medical Assistance Program in Section 450.101.)

(2) Medical services provided under the General Relief Medical Assistance Program are reimbursed entirely with state funds and are more limited in scope than services reimbursed through the Medical Assistance Program. In general, Chapters 400 through 499 of Title 106 of the Code of Massachusetts Regulations (CMR) apply to both the Medical Assistance Program and the General Relief Medical Assistance Program, but subject always to the limitations on the medical services compensable under the General Relief Medical Assistance Program. (See Section 450.107.)

450.105: Categories of Assistance

(A) Medical Assistance Recipients. Medical Assistance recipients are classified according to the following categories of assistance:

Category 00 -- Cuban Refugee Program and Vietnamese and Cambodian Refugee Program
01 -- SSI/Aged (Supplemental Security Income for recipients 65 years of age or over)
02 -- AFDC (Aid to Families with Dependent Children)
03 -- SSI/Disabled (Supplemental Security Income for disabled recipients)
05 -- MA/Aged (Medical Assistance for recipients 65 years of age or over)
06 -- MA/AFDC (Medical Assistance/Aid to Families with Dependent Children)
07 -- MA/Disabled (Medical Assistance for disabled recipients)

08 -- MA/Under 21 (Medical Assistance for recipients under 21 years of age)

(B) General Relief Recipients. General Relief recipients are classified according to the following category of assistance:
Category 04 -- General Relief

450.106: Eligible Recipients

(A) Introduction. Eligibility for the Medical Assistance Program is determined pursuant to 106 CMR 324.000, 325.000, and 328.000. Eligibility for the General Relief Medical Assistance Program is determined pursuant to 106 CMR 323.000. Each month the Department issues a new Medicaid Eligibility Card to the card holder (usually the head of household), sometimes called the grantee. The name of each eligible person (recipient) in the card holder's household is listed on the Medicaid Eligibility Card or on the Temporary Medicaid Eligibility Card. The card is evidence of eligibility to receive medical services reimbursable under the Medical Assistance Program or the General Relief Medical Assistance Program and is valid for the dates specified on the card.

(B) Assurance of Eligibility. Because payment can be made only for medical services for which the recipient was eligible as of the date of service, and because of the time limits on submission of claims, providers must exercise care and diligence at the time the service is requested to ascertain whether the patient is an eligible recipient of the service to be provided. While it is permissible to warn a patient that he may be personally obligated to pay for a service for which he is not eligible, a provider may be unable to assert his claim against either the Department or the patient, if the patient actually was eligible on the date of service and the provider fails to ascertain that fact in time to meet the deadline for submission of the claim. A current Medicaid Eligibility Card or Temporary Medicaid Eligibility Card is the only assurance of eligibility available to a provider. The fact that a patient was eligible on a given date does not mean that he was eligible on a succeeding or prior date. Therefore, for all services, the provider must carefully check the Eligibility Card, taking care to observe all service restrictions and eligibility dates noted on the card. Questions concerning service restrictions should be directed to the Medical Division. Questions concerning eligibility dates should be directed to the recipient's Welfare Service Office.

(C) Claims Reconsideration When Eligibility or Service Restrictions Are Not Revealed on Eligibility Card. In rare instances, a recipient may produce an Eligibility Card issued by the Department that fails to reveal the existence of an eligibility or service restriction in effect on the date of service. In such instances, the Department will reconsider a claim that has been rejected because of eligibility or service restrictions not revealed by the card, but only if the provider furnishes proof satisfactory to the Department that an Eligibility Card

presented by the recipient failed to reveal the existence of the eligibility or service restriction on which the rejection was based, and of which the provider had no other notice. In most instances, satisfactory proof will be a clear photocopy of the card. Therefore, the Department recommends that providers photocopy the Eligibility Card in all doubtful cases. (See Section 450.322 for information on appeals of erroneously denied claims.)

450.107: Reimbursable Medical Services

The following table summarizes reimbursable and nonreimbursable medical services for recipients in the Medical Assistance Program (MA) and for recipients in the General Relief Medical Assistance Program (GR). There are program regulations for each of the program areas listed below, which are amended from time to time. A provider must refer to the program regulations applicable to his provider type for specific information concerning which services are covered for the various recipient categories.

Services Reimbursable for MA and GR	Services Reimbursable for MA; Reimbursable for GR with Restrictions	Services Reimbursable for MA; Not Reimbursable for GR
Home health services	Community health center services	Abortion services
Independent laboratory services	Dentistry	Adult day health services
Laboratory services provided in the physician's office	Drugs	Adult foster care services
	Durable medical goods, including prosthetics and hearing aids	Center for independent living services
	Physician services, including specialty services	Chronic hospital services
	Sterilization services	Free-standing family planning agency services
	Vision care services	Free-standing kidney disease center services
		Free-standing mental health clinic services
		Hospital services (all departments) (life-sustaining drugs are reimbursable when provided to GR)
		Intermediate care facility for the mentally retarded services
		Nursing home services
		Physical, occupational, and speech therapy
		Physician services provided in a hospital
		Podiatry
		Private duty nursing
		Psychiatric day treatment/ day habilitation center services
		Psychological testing
		Specialty clinic services (including amputee clinics, rehabilitation clinics, audiological and hearing aid evaluation centers)
		Transportation

(106 CMR 450.108 through 450.200 Reserved)

450.201: Choice of Provider

Pursuant to federal regulations set forth in 42 CFR 431.51, recipients have the right to choose providers from whom to obtain medical services with certain exceptions that are specified in the program regulations. However, a recipient's right to choose a provider does not permit or require payment by the Department to any person or institution not eligible for such payment under the Department's regulations in effect at the time a medical service is furnished.

450.202: Discrimination

(A) M.G.L. c. 151B, s. 4, clause 10 prohibits discrimination against any individual who is a recipient of federal, state, or local public assistance, including medical assistance, solely because the individual is such a recipient. Accordingly, except as specifically permitted or required by regulations relative to institutional providers, no provider shall deny any medical service to a recipient eligible for such service unless the provider would, at the same time and under similar circumstances, deny the same service to a patient who is not a Medical Assistance recipient (e.g., no new patients are being accepted, or the provider does not furnish the desired service to any patient). A provider shall not specify a particular setting for the provision of services to a recipient that is not also specified for nonrecipients in similar circumstances.

(B) No provider shall engage in any practice, with respect to any recipient, that constitutes unlawful discrimination under any other state or federal law or regulation, including but not limited to practices that violate the provisions of 45 CFR Part 80 (relative to discrimination on account of race, color, or national origin), 45 CFR Part 84 (relative to discrimination against handicapped persons), and 45 CFR Part 90 (relative to age discrimination).

(C) Violations of the regulations set forth in Subsections (A) and (B) above may result in administrative action, referral to the Massachusetts Commission against Discrimination, or referral to the U.S. Department of Health, Education and Welfare, or any combination of these.

450.203: Payment in Full

Federal and Massachusetts law require that participation in the Medical Assistance Program be limited to providers that agree to accept, as payment in full, the amounts paid in accordance with the applicable fee and rate schedules (see 42 CFR 447.15, M.G.L. c. 118E, s 18, and M.G.L. c. 6A, s. 35). No provider shall solicit, charge, receive, or accept any money, gift, or other consideration from a recipient, or from any other person, for any item of medical service for which payment is available under the Medical Assistance Program, in addition to, in lieu of, or as an advance or deposit against the amounts paid or payable by the Department for such item, except to the extent that the

regulations specifically require or permit contribution or supplementation by the recipient or by a health insurer. (For instances of retroactive recipient eligibility, see Subsection 450.311(B).)

450.204: Medical Standards

A provider must furnish or prescribe medical services to the recipient only when, and to the extent, medically necessary, unless otherwise specified in Department regulations. For the purposes of this Chapter 450.000, a service is "medically necessary" if it is (1) reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and (2) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly. Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality. Those records shall be made available to the Department upon request. (See 42 U.S.C. 1396a(a)(30), and 42 CFR 440.230(C)(2) and 440.260.)

450.205: Recordkeeping and Disclosure

(A) Documentation to substantiate the furnishing of services reimbursable under the Medical Assistance Program is an integral part of such services for which reimbursement is made. All providers must keep such records as are necessary to disclose fully the extent of services furnished to recipients, and must furnish to the Department or the Medicaid Fraud Control Unit on request such information and any other information regarding payments claimed by the provider for furnishing services (see 42 U.S.C. 1396a(a)(27) and the regulations thereunder). Such records shall be maintained for at least four years after the date of medical services for which claims are made or for such length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever time period is longer. Institutional providers shall, in addition, furnish to the Department upon request all records maintained by or within the institution regarding services furnished to recipients by other providers.

(B) In those instances where Department regulations specify the minimum content of records substantiating particular services, or services provided by particular types of providers, such regulations shall constitute the standard against which the adequacy of records shall be measured for the purposes of this regulation. In all other instances, the adequacy of records shall be determined by the generally accepted standards for recordkeeping within the applicable provider type as they may be found in statutes, and in rules and regulations of the relevant board of registration, in professional treatises, and in guidelines and

other information published, adopted, or promulgated by state or national professional organizations and societies. In no instance shall the completion of the appropriate Department claim form, the maintenance of a copy of such completed form, or the simple notation of service codes constitute sufficient documentation for the purpose of this regulation.

(C) The records and information required to be maintained or disclosed under this section include only those that relate in any manner to services to recipients, provided, however, that disclosure may not be refused on the ground that such records are commingled with records related to persons who are not recipients. Such records and information shall be made available to the Department for examination or copying during reasonable office hours at the provider's place of business or record depository.

(D) In cases where Department audits have revealed provider noncompliance with Subsections (A) through (C) above, the Department may seek to pursue recovery of overpayments or to impose sanctions in accordance with the provisions of Sections 450.234 through 450.258.

450.206: Determination of Compliance with Medical Standards

Violations of Section 450.204 may be determined by peer review. Except as otherwise required by law, the Department shall decide the level or manner of peer review in each instance. Such peer review may be conducted by a qualified Department employee or consultant or by one or more qualified persons provided by health-care foundations, professional societies, or such other professional organizations as the Department may select. In appropriate cases, the Department may rely in part or in whole upon reviews conducted by a Professional Standards Review Organization or a board of registration. In the event that the Department decides to pursue any sanction or recovery of overpayments as a result of a peer-review recommendation, the provisions of Sections 450.234 through 450.258 shall apply.

(106 CMR 450.207 through 450.210 Reserved)

450.211: Provider Eligibility: Eligibility Criteria

To be eligible to participate in the Medical Assistance Program as a provider type, a provider must meet the eligibility criteria applicable to that type, which include:

(A) all statutory prerequisites applicable to such type;

(B) all conditions of participation made applicable to such type by regulations promulgated by the U.S. Department of Health, Education and Welfare under Titles XVIII and XIX of the Social Security Act; and

(C) all conditions of participation made applicable to such type by regulations promulgated by the Department. Program regulations applicable to specific provider types appear in Chapters 400 through 499 of Title 106 of the Code of Massachusetts Regulations (CMR).

450.212: Provider Eligibility: Termination of Participation for Ineligibility

When a participating provider fails or ceases to meet any one or more of the eligibility criteria applicable to such provider, the provider's participation in the Medical Assistance Program may be terminated, subject to Section 215. If such termination is based upon a finding, ruling, decision, or notification by any federal, state, or quasi-public board, department (other than the Department), or other agency that revokes, voids, suspends, or denies the issuance, renewal, or extension of a license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion, the correctness or validity of the action taken by the issuing agency shall be presumed, the termination shall be effective as of the earliest date on which the provider failed or ceased to meet any of such criteria, and the Department shall not afford a hearing as to the correctness or validity of such action. If such termination is based solely upon a determination of ineligibility by the Department, the provider shall be afforded notice and an opportunity for hearing in substantially the manner set forth in Sections 450.243 through 450.256, and the termination shall be effective as of the date of receipt of notice thereof.

450.213: Provider Eligibility: Suspension of Participation Pursuant to U.S. Department of Health, Education and Welfare Order

When a participating provider is the subject of a notice by the U.S. Department of Health, Education and Welfare requiring the provider's suspension or the denial, termination, or refusal to renew a provider agreement pursuant to Section 1902(a)(39) (42 U.S.C. 1396a(a)(39)) or any other section of the Social Security Act, the provider's participation in the Medical Assistance Program shall be suspended or its provider agreement shall be denied, terminated, or not renewed in accordance with the Department of Health, Education and Welfare notice; subject, however, to the provisions of Section 450.215. The Department shall not afford a hearing to the provider as to the correctness or validity of the action taken by the Department of Health, Education and Welfare.

450.214: Provider Eligibility: Notification of Potential Changes in Eligibility

(A) The provider will notify the Medical Division as soon as possible, in writing, of any written communication by or through an issuing agency that purports or expresses an intention, conditionally or otherwise, to revoke, void, suspend, or deny the issuance, renewal, or

extension of any license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion; provided, however, that such notice need not be given if the issuing agency has itself so notified the Medical Division. The provider will notify the Medical Division as soon as possible of any communication made by the provider to an issuing agency that purports or expresses an intention or desire to surrender or otherwise to terminate or substantially modify the conditions of any such license, certificate, or other statement of qualification. The Department will not review or entertain any appeal from the actions or omissions of the issuing agency, but the Department shall have the right, subject to the rules and regulations of the issuing agency, to appear and offer evidence in any proceeding before the issuing agency, or any appeal from such proceeding.

(B) Without limiting the generality of the Subsection (A) above, the provider will notify the Medical Division as soon as possible, in writing, whenever:

(1) the provider has received notice of denial of Medicare or Medicaid certification from the Massachusetts Department of Public Health, when such certification is an eligibility criterion;

(2) the provider has received notice of a denial of an application for renewal of a license from the Department of Public Health, when such licensure is a statutory prerequisite;

(3) the provider has filed application with the Department of Public Health to convert from nursing home to rest home status; or

(4) the provider has received an order to show cause from a board of registration, when certification from that board is a statutory prerequisite.

450.215: Provider Eligibility: Limitations on Participation pending Eligibility Decision or Status Change

If termination or suspension of a provider's participation in the Medical Assistance Program pursuant to Sections 450.212, 450.213, and 450.241 through 450.256 has occurred or is imminent, the Department shall take such action as may be reasonably necessary or appropriate to prevent or to mitigate injury to recipients or the Medical Assistance Program or both resulting from such termination or suspension. Such action may be taken immediately upon notice thereof to the provider notwithstanding the exercise of such rights as the provider may have to secure administrative or judicial review of the action of the issuing agency, or of the U.S. Department of Health, Education and Welfare, or of the Department, or any combination of them. Such action may include a request to the Department of Health, Education and Welfare pursuant to Section 1902(g) of the Social Security Act (42 U.S.C. 1396a(g)). With respect to chronic disease and rehabilitation hospitals and other long term care facilities, such action may include an order barring further admissions of recipients pending final resolution of the issues that prompted such action, or an order that the institution shall

continue to be paid by the Department, for a period specified in the order, for services to recipients admitted to the facility prior to an order barring new admissions, or prior to such termination. Such action shall be reasonably calculated to achieve, so far as possible, the following goals:

(A) protecting the health and safety of recipients, including present and prospective patients of the provider; and

(B) maximizing federal financial participation in the cost of medical assistance.

450.216: Provider Eligibility: Ineligibility of Suspended Providers

A provider suspended from participation for violations of rules, regulations, laws, or standards governing the Medical Assistance Program shall not be eligible to participate during the period of such suspension. If the violations resulted in overpayments, the Department may deny the participation of such provider until such time as arrangements satisfactory to the Department have been made for the restitution of all overpayments.

(106 CMR 450.217 through 450.220 Reserved)

450.221: Provider Agreement: Definitions

(A) Defined Terms. For the purposes of Sections 450.222 through 450.228, the following words and expressions shall have the indicated definitions. These definitions as they are applied in Sections 450.222 through 450.228 are adopted pursuant to the provisions of 42 U.S.C. Sections 1302, 1320a-3, 1320a-5, 1396a(a)38, 1396b(i)(2), and 1396b(n), and regulations at 42 CFR 455.100 et seq.

(1) Agent -- any person who has been delegated the authority to obligate or act on behalf of a provider.

(2) Convicted -- a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

(3) Disclosing Entity -- a provider or fiscal agent.

(4) Other Disclosing Entity -- any other disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Titles V, XVIII, or XX of the Social Security Act. This includes:

(a) any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare;

(b) any Medicare intermediary or carrier; and

(c) any entity (other than an individual practitioner or group practice organization that furnishes, or arranges for the furnishing of, health-related services for which it claims payment

under any plan or program established under Titles V or XX of the Social Security Act).

(5) Fiscal Agent -- a contractor that processes or pays for provider claims on behalf of the Department.

(6) Indirect Ownership Interest -- an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

(7) Managing Employee -- a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

(8) Ownership Interest -- the possession of equity in the capital, the stock, or the profits of the disclosing entity.

(9) Person with an Ownership or Control Interest -- a person or corporation that:

(a) has an ownership interest totaling five percent or more in a disclosing entity;

(b) has an indirect ownership interest equal to five percent or more in a disclosing entity;

(c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity;

(d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity;

(e) is an officer or director of a disclosing entity that is organized as a corporation;

(f) is a partner in a disclosing entity that is organized as a partnership; or

(g) owns directly or indirectly an interest of five percent or more in any real property leased to a disclosing entity for use as a nursing home, rest home, or hospital.

For the purpose of this definition, an individual shall be deemed to own any beneficial interest owned directly or indirectly by or for his minor children or spouse.

(10) Significant Business Transaction -- any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or five percent of a provider's total operating expenses.

(11) Secretary -- the Secretary of the U.S. Department of Health, Education and Welfare or any successor agency.

(12) Subcontractor --

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

(13) Supplier -- an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
(14) Wholly Owned Supplier -- a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

(B) Determination of Ownership or Control Percentages. For the purposes of the definitions in Subsection (A) above, ownership or control percentages shall be determined as follows.
(1) Indirect Ownership Interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an eight-percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns five percent of the stock of the disclosing entity, B's interest equates to a four-percent indirect ownership interest in the disclosing entity and need not be reported.
(2) Person with an Ownership or Control Interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to six percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to four percent and need not be reported.

450.222: Provider Agreement: Application for Agreement

(A) Subject to the exception set forth in Subsection (C) below, relative to out-of-state providers, any provider that is not a participating provider on the effective date of this regulation, and any provider that, by reason of suspension or withdrawal, ceases to be a participating provider after such date, may become a participating provider only by the submission of an application filed on its behalf with the Medical Division by the intended contractor. Any provider that is and continues to be a participating provider on and after the effective date of this regulation shall cause such an application to be filed on its behalf by the intended contractor when and as requested to do so by the Department. The application shall be deemed to be part of any subsequent provider agreement between the applicant and the Department. Any material omission or misstatement in the application or the contractor's failure to disclose fully and accurately at any time the information described in Subsection (B)(6) below shall (without limiting any other penalties or sanctions resulting therefrom) render such agreement voidable by the Department.

(B) The application shall contain the following information:
(1) the provider's name and the street address at or from which the provider does business;
(2) the contractor's name and mailing address, and identification as an individual, corporation, trust, or partnership;
(3) the contractor's Federal Identification Number (i.e., the Social Security Number if the contractor is an individual without employees; otherwise the Federal Employer Identification Number);
(4) the name, address, and Social Security Number of each person with an ownership or control interest in the contractor, or in any subcontractor in which the contractor has direct or indirect ownership of five percent or more including, in cases where more than one name appears, the fact, if it be a fact, that such persons are related as spouse, parent, child, or sibling;
(5) the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
(a) keep copies of all these requests and the responses to them;
(b) make them available to the Secretary or the Department upon request; and
(c) advise the Department when there is no response to a request.
(6) the identity of any person who:
(a) has an ownership or control interest in the contractor, or is an agent or managing employee of the provider; and
(b) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the social services program under Title XX of the Social Security Act since the inception of these programs; and
(7) such other information as the Department may require, including but not limited to information relative to:
(a) the nature and scope of medical services to be furnished by the provider;
(b) ownership of equipment and facilities employed by the provider; and
(c) licenses, accreditations, degree, specialty and board certification, and other qualifications of the provider to furnish such services.

(C) In lieu of the application described in Subsections (A) and (B) above, an out-of-state provider that does not operate or have a place of business in Massachusetts may submit proof satisfactory to the Department that it is a participating provider in the Title XIX Program of another state.

(D) In lieu of completing the application with respect to the information described in Subsections (B)(4) and (B)(5) above, any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply this information to the

Massachusetts Department of Public Health at the time it is surveyed. In the event it fails to do so or in the event this information is not solicited, it shall be required to supply the information to the Department.

450.223: Provider Agreement: Execution of Agreement

(A) If the intended contractor has filed a complete and properly executed application, and nothing in the application or any other information in the possession of the Department reveals any bar or hindrance to the participation of the provider for whom the application was filed, the Department shall prepare and furnish as soon as possible a provider agreement that, when fully executed by the contractor and the Department, shall take effect as of the effective date stated in the provider agreement. At its discretion, the Department may prepare and furnish application blanks in such form that the completed application itself, when countersigned by the Department and delivered to the provider, shall constitute the provider agreement; provided, however, that such an application may be withdrawn by the applicant by written notice received by the Department prior to the applicant's receipt of the countersigned application.

(B) Each contractor shall notify the Department as soon as possible of any material change in any of the information submitted in the application form. Failure to do so shall constitute a breach of the provider agreement. At its discretion, the Department may require contractors to recertify, at reasonable intervals, the continued accuracy and completeness of the information contained in the contractor's application, except that the contractor must disclose to the Department the information described in Subsection 450.222(B)(6) at any time upon the Department's written request; however, no failure by the Department to require recertification shall relieve the contractor's obligation under the first sentence of this subsection.

(C) The following provisions shall be a part of every provider agreement whether or not they are included verbatim or specifically incorporated by reference.

(1) The contractor (provider) agrees to comply with all laws, rules, and regulations governing the Medical Assistance Program (see M.G.L. c. 118E, s. 18).

(2) The contractor (provider) agrees that the submission of any claim by or on behalf of the provider shall constitute a certification (whether or not such certification is reproduced on the claim form) that:

(a) the medical services for which payment is claimed were furnished in accordance with Section 450.301;

(b) the medical services for which payment is claimed were actually furnished to the person identified as the recipient at the time and in the manner stated;

(c) the payment claimed does not exceed the maximum amount payable under applicable regulations of the Massachusetts Rate

Setting Commission, including any limitations therein expressed in terms of the provider's usual or customary charges;

(d) the payment claimed will be accepted as full payment for the medical services for which payment is claimed, except to the extent that the regulations specifically require or permit contribution or supplementation by the recipient or by a health insurer and subject to adjustments by the Rate Setting Commission;

(e) the information submitted in, with, or in support of the claim is true, accurate, and complete; and

(f) the medical services were provided in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

(3) The contractor (provider) agrees to keep for such period of time as may be required by Subsection 450.205(A) such records as are necessary to disclose fully the extent of services furnished to recipients, and on request to furnish the Department or the Medicaid Fraud Control Unit with such information and any other information regarding payments claimed by the contractor for furnishing services (see 42 U.S.C. 1396a(27) and the regulations thereunder).

(4) This agreement may be terminated by the Department if the provider shall fail or cease to satisfy all applicable criteria for eligibility as a participating provider.

(5) The contractor (provider) agrees to submit, within 35 days after the date of a request by the Secretary or the Department, full and complete information about:

(a) the ownership of any subcontractor with whom the contractor (provider) has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request;

(b) any significant business transactions between the contractor (provider) and any wholly owned supplier, or between the contractor (provider) and any subcontractor, during the five-year period ending on the date of the request; and

(c) any information necessary to update fully and accurately, as of the date of the request, any information described in Subsections 450.222(B)(4) and (B)(5) that the contractor has previously delivered to the Department or to the Massachusetts Department of Public Health.

(6) The contractor agrees that the Department may offset any sums payable by reason of a retroactive rate increase for any period during which the contractor owned or operated part or all of a facility against any sums due the Department by reason of a retroactive rate decrease for any periods.

(D) The provisions of Sections 450.222 and 450.223 shall apply to any provider agreement made on or after the effective date of this regulation, including any extension or renewal of a provider agreement made prior to such effective date.

450.224: Provider Agreement: Ineligibility of Convicted Provider

The Department may refuse to enter into or to renew a provider agreement with any contractor on behalf of any provider if such provider, any party in interest in such provider, or an agent or managing employee of such provider, has been convicted of a criminal offense relating to that person's involvement in any program established under Titles XVIII, XIX, or XX of the Social Security Act, or of a crime of such a nature that, in the judgment of the Department, the participation of such provider will compromise the integrity of the Medical Assistance Program.

450.225: Provider Agreement: Individual Practitioners

(A) Any individual practitioner must personally execute a provider agreement as the contractor with respect to his furnishing any medical services, excluding those services covered by Subsection 450.301(B). The intent of this section is that any individual practitioner may be held personally accountable under the provisions of Sections 450.234 through 450.238 and Sections 450.241 through 450.258 for all medical services billed under his provider number.

(B) Any individual practitioner who desires to bill the Department for services furnished by any other individual practitioner, and any other person or other legal entity that desires to bill the Department for services furnished by individual practitioners in accordance with the fee schedules applicable to individual practitioners, must submit an application in accordance with the provisions of Sections 450.331 through 450.338.

450.226: Provider Agreement: Issuance of Provider Numbers

(A) Upon execution of the provider agreement, the Department will issue a provider number to be used to identify the provider that is the subject of the agreement in claim forms and other communications with the Department. Consistent with the definitions in Subsections 450.101(K) and (CC), separate facilities or locations owned or operated by the same contractor may be the subject of separate provider agreements with the contractor, in which case each such facility or location may be issued a separate provider number for its exclusive use. Also, the Department may issue two or more provider numbers to a health maintenance organization (defined in 42 U.S.C. 1395mm(b) and 42 CFR 405.2001), a hospital, or a similar organization or institution when the administrative convenience of the Department is served by the issuance of more than one provider number. Except in the circumstances described in this section, no provider shall have or use more than one provider number in any one provider type.

(B) For every case in which a contractor is assigned two or more provider numbers, the contractor must employ each provider number only

in conjunction with the facility or location to which the number is assigned. In addition, the Department may condition the assignment of multiple provider numbers upon the express written agreement of the contractor that the Department may commence proceedings in accordance with the provisions of Sections 450.234 through 450.258 against any or all of its provider numbers, regardless of the location or facility where the violation has been alleged to have occurred or the overpayment received.

450.227: Provider Agreement: Termination or Disapproval for Nondisclosure

(A) The Department shall not approve a provider agreement, and must terminate an existing agreement, if the contractor fails to disclose any information in accordance with the provisions of Subsections 450.222(B)(4), (B)(5), and (D), or Subsection 450.223(C)(5)(c).

(B) The Department may refuse to approve a provider agreement, and may terminate an existing agreement, if the contractor fails to disclose any information in accordance with the provisions of Subsections 450.223(C)(5)(a) and (C)(5)(b), or a request by the Secretary in accordance with federal regulations at 42 CFR 420.205.

450.228: Fiscal Agents: Disclosure of Information

(A) Every fiscal agent must disclose to the Department the information described in Subsections 450.222(B)(4) and (B)(5) before entering into a contract with the Department.

(B) Within 35 days after the date of a written request by the Secretary or the Department, every fiscal agent must provide any information necessary to update fully and accurately, as of the date of the request, any information described in Subsection (A) above.

(C) The Department shall not approve a contract with a fiscal agent, and must terminate an existing contract, if the fiscal agent fails to comply with the provisions of this section.

(106 CMR 450.229 through 450.230 Reserved)

450.231: Limitations of Payments: Participation of Both Provider and Recipient

(A) Except to the extent otherwise permitted under these or federal regulations, no provider shall be entitled to any payment or reimbursement under the Medical Assistance Program unless the provider was a participating provider as of the date of the medical services for which payment is sought, and the person to whom the medical services were provided was a recipient as of the date on which the services were provided.

(B) The "date of service" is the date on which a medical service is furnished to a recipient or, if the medical service consists princi-

pally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a recipient. If a provider delivers medical goods to a recipient, which goods had to be ordered, fitted, or altered for the recipient, and that recipient ceases to be eligible for Medical Assistance on a date prior to the final delivery of the goods, the Department will reimburse the provider for the goods only under the following circumstances:

(1) the recipient must have been eligible for Medical Assistance on the date of the recipient's last visit with the provider before the provider orders or fabricates the goods;

(2) the date on which the provider orders or fabricates the goods occurs no later than seven days after the last visit or the provider's receipt of a prior authorization in the case of those goods requiring same, whichever event is later;

(3) the provider submits documentation with the claim to the Department that verifies both the date of the recipient's last visit that occurred before the provider ordered or fabricated the goods and the date on which the goods were actually ordered or fabricated;

(4) the provider must not accept any payment from the recipient for the goods; and

(5) the provider must attempt to deliver the goods to the recipient.

For the purposes of this section, a provider who directly services the recipient and who also produces the goods for delivery to the recipient has "fabricated" an item if he has taken the first substantial step necessary to initiate the production process after the conclusion of all necessary recipient visits.

(C) For retroactive eligibility of recipients and providers, see Sections 450.311 and 450.312. For payment to providers furnishing emergency services, see 42 CFR Part 440.

450.232: Limitations of Payments: Maximum Allowable Amount to In-State Providers

(A) Payment to a Massachusetts institutional provider for any medical services compensable under the Medical Assistance Program shall be in accordance with the rate schedule applicable to the provider. (Rates are established by the Massachusetts Rate Setting Commission under M.G.L. c. 6A.)

(B) Payment to a Massachusetts provider other than an institution for any medical services compensable under the Medical Assistance Program shall be in accordance with the applicable fee schedule established by the Rate Setting Commission, subject to any limitation in the schedule expressed in terms of the provider's usual or customary fee for that service (see 42 CFR 447.352).

450.233: Limitations of Payments: Maximum Allowable Amount to Out-of-State Providers

(A) Payment for any medical services compensable under the Massachusetts Medical Assistance Program to an out-of-state institutional provider whose rates are not established by the Massachusetts Rate Setting Commission shall be in accordance with the rate schedule applicable to the provider under that state's Medical Assistance Program. The provider must submit satisfactory evidence of such rate, such as a copy of the applicable rate schedule.

(B) Payment for any medical services compensable under the Massachusetts Medical Assistance Program to an out-of-state hospital, whose rates are not established by the Rate Setting Commission or under another state's Medical Assistance Program, for inpatient services, shall be made in accordance with the weighted average inpatient per diem rate for Massachusetts hospitals as calculated for the rates in effect for the first day of October immediately prior to the dates of service. Payment for outpatient services will be made at 100 percent of the hospital's charges.

(C) Payment to an out-of-state provider other than an institution for any medical services compensable under the Massachusetts Medical Assistance Program shall be in accordance with the applicable fee schedule established by the Rate Setting Commission, subject to any limitation in the schedule expressed in terms of the provider's usual or customary fee for that service (see 42 CFR 447.352).

450.234: Limitations of Payments: Definition of Overpayment

Overpayments include, but are not necessarily limited to, payments to a participant:

(A) for medical services that were not actually furnished, or that were furnished to a person who was not a recipient as of the date of such services;

(B) for medical services that were not reimbursable under the Medical Assistance Program at the time the services were provided, including services that were reimbursable only when furnished by a provider of a different provider type, and including medical services that were not medically necessary (as defined in Section 450.204);

(C) in excess of the maximum amount properly payable for the medical service furnished, to the extent of such excess;

(D) for medical services for which payment has been received from health insurers, workmen's compensation insurers, other third-party payers, or recipients;

(E) for medical services for which the provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state statutes and regulations; or

(F) for medical services furnished when, as of the date of services, the provider was not a participating provider, or was in substantial breach or default of the provider agreement.

450.235: Limitations of Payments: Calculation of Overpayments by Sampling

In any action or administrative proceeding to determine or to recover overpayments, the Department may ascertain the amount of overpayments that have been made to a provider over a given period by reviewing a representative sample drawn from the entire number of claims paid during that period, and extrapolating the results of the review over the entire period. The Department shall employ statistically valid techniques in establishing the size and distribution of the sample, to ensure that it is a valid and representative sample of the body of claims from which it is drawn. The method described in this section shall not be used to calculate overpayments resulting from retroactive rate adjustments made to the rates of institutional providers pursuant to M.G.L. c. 6A, s. 32.

450.236: Limitations of Payments: Determination of Overpayments

The fact and amount of overpayments may be determined in an action to recover the same in any court having jurisdiction. Additionally or alternatively, the Department may determine the fact and amount of overpayments, except overpayments resulting from retroactive adjustments made to the rates of institutional providers pursuant to M.G.L. c. 6A, s. 32, by any of the following procedures.

(A) When some or all of the overpayments are alleged to have resulted from violation of rules, regulations, standards, or laws governing the Medical Assistance Program, and the Department intends both to impose sanctions against the participant and to recover overpayments, determination of the fact and amount of overpayments may be made in a sanctions proceeding, as described in Sections 450.241 through 450.258.

(B) When some or all of the overpayments are alleged to have resulted from violation of rules, regulations, standards, or laws governing the Medical Assistance Program, and the Department intends to recover overpayments, but is prepared to forego the imposition of sanctions for such violations, determination of the fact and amount of overpayments may be made as follows.

(1) The Department shall notify the participant by certified mail of the nature of the violations, a description of the sanctions that would be imposed in the absence of a waiver, and the amount of the overpayments. Such Notice of Overpayment shall refer specifically

to this section, and shall be accompanied by an unsigned agreement, in which the participant agrees to restore all claimed overpayments, and in which the Department agrees to waive its right to impose sanctions based on the alleged violations and to accept the claimed amount in full satisfaction of all overpayments arising out of the alleged violations.

(2) If the participant elects not to dispute the allegations in the Notice of Overpayment, the participant shall sign the agreement and return it to the Department on or before the twenty-first day after the date of receipt of the Notice of Overpayment. The participant may make payment to the Commonwealth of Massachusetts in the amount of the alleged overpayments with the agreement. If the signed agreement is returned without payment of the full amount, the Department may either reject the agreement and proceed in accordance with Subsection (A) above or it may elect to recover the amount of overpayments not restored by any method described in Section 450.258, and the agreement shall be binding on the Department when the full amount has been recovered.

(3) If the participant desires to preserve his rights to an adjudicatory proceeding and judicial review, he shall advise the Department, in writing, on or before the twenty-first day after the date of receipt of the Notice of Overpayment, that he elects to treat the Notice of Overpayment as a Notice of Violation under the sanctions procedure described in Sections 450.241 through 450.258, in which case he must file a reply in accordance with the provisions of Section 450.244. In the event of such an election, the Department will not be deemed to have waived the right to impose the sanctions described in the Notice of Overpayment.

(4) If the participant fails to respond to the Notice of Overpayment in the manner and within the time specified in Subsections (1), (2), and (3) above, the participant shall be deemed to have admitted the violations and the overpayments alleged in the notice, and the Department may take appropriate action relative to the recovery of overpayments.

(C) When none of the overpayments are alleged to have resulted from violations of rules, regulations, standards, or laws governing the Medical Assistance Program (as in the case of an overpayment made as a result of an error by the Department), the Department shall notify the participant in writing of the nature and amount of the overpayments. The procedures described in Subsection (B) above shall be followed, except that:

(1) references therein to violations and sanctions shall not apply; and

(2) the election by the participant to treat the Notice of Overpayment as a Notice of Violation may be made even though no violations are alleged.

Nothing herein shall be construed to require the Department to afford a hearing unless the Notice of Overpayment and the provider's reply disclose a dispute as to a material fact or a question of law.

450.237: Limitations of Payments: Extension of Time for Participant's Reply

The Department for good cause shown may at any time in its discretion extend the response times set forth in Section 450.236, upon the participant's written request.

450.238: Limitations of Payments: Withholding of Payments

(A) "Withholding of Payments" means the withholding of all or a specified amount or a specified percentage of payments otherwise payable to a provider in the circumstances and for the purposes described in this section. During the pendency of an order to withhold payments, the Department will continue to process the provider's pending and subsequent claims. Therefore, to avoid rejection of otherwise proper claims because of late submission, a provider must continue to submit proper and timely claims for medical services furnished to recipients during the pendency of an order to withhold payments.

(B) The Department may order withholding of payments to a provider in any case in which it has reasonable cause to believe that overpayments have occurred; provided, however, that the information on which such belief is based has been referred to the Medical Division's Provider Review/Sanctions Unit for preparation of a Notice of Violation pursuant to Section 450.243, or a Notice of Overpayment pursuant to Subsections 450.236(B) or (C). The Department shall estimate the amount of overpayment based on such information, and the order shall be limited accordingly. The Department shall send a Notice of Withholding of Payments to the provider by certified mail, stating the date and terms of the order and giving a concise summary of the reason for the order. Subsequent orders to withhold payments based on the same or additional information may be made in the same manner as an original order. No order to withhold payments shall be amended so as to increase the amount or rate thereof retroactively for any period prior to the date of the amendment. An order to withhold payments under this Subsection (B) shall expire on the sixty-first day after its date unless before such date the provider has received either a Notice of Violation or a Notice of Overpayment, in which event the order shall continue in effect until the provider's entitlement to the withheld funds and the amount of overpayments have been finally adjudicated and any overpayments have been recovered. In no event will an order to withhold payments be effective for an amount in excess of the amount that the Department seeks to recover as stated in a Notice of Violation or a Notice of Overpayment.

(C) If the Department receives notice from the U.S. Department of Health, Education and Welfare of an order for suspension of payments to a provider under Subsection 1160(c) (42 U.S.C. 1320c-9), Section 1903(j) (42 U.S.C. 1396b(j)) or any other section of the Social Security Act, the Department shall withhold payments otherwise due the provider in accordance with the terms of the notice. The Department shall promptly

notify the provider of such action and the reason for it. Notwithstanding the foregoing, the Department shall take such other action as may be necessary or appropriate to ameliorate the effect of actions taken under this section on recipients and on the Medical Assistance Program, including action similar to that described in Section 450.215. An order to withhold payments under this Subsection (C) shall continue until such time as the underlying Department of Health, Education and Welfare order shall have been rescinded, or shall have become final and unappealable, at which time apportionment of the withheld amounts between the Department and the provider shall be made accordingly.

(106 CMR 450.239 through 450.240 Reserved)

450.241: Sanctions: General

All participants are subject to the rules, regulations, standards, and laws governing the Medical Assistance Program (see M.G.L. c. 118E, s. 4 and 18). Sections 450.241 through 450.258 set forth the Department's procedures for securing compliance with those rules, regulations, standards, and laws, and for imposing sanctions and penalties for violations. The sanctions procedures may also be used for recovery of overpayments whether or not violations are alleged in those proceedings, even though the recovery of an overpayment is not itself a sanction (see Section 450.236). On the other hand, the Department may refrain from alleging and proving overpayments at any stage prior to the actual commencement of a hearing in a sanctions proceeding without waiving the Commonwealth's right to recover overpayments in another proceeding. These sanctions procedures shall be applicable to the conduct of any participant during the period of his participation in the Medical Assistance Program, whether or not the provider is a participating provider or the billing intermediary is an authorized billing agency or authorized group practice organization at the time such procedures are applied.

450.242: Sanctions: Penalties

The Department is required to establish sanctions against providers and may establish sanctions against billing intermediaries for violations of the rules, regulations, standards, or laws governing the Medical Assistance Program (see M.G.L. c. 118E, s. 4 and 19). Such sanctions may include, but are not limited to, suspension from participation in the Medical Assistance Program, subject to any statutory limits on the period of the suspension.

450.243: Sanctions: Notice of Violation

If the Department has reason to believe that a participant has committed one or more violations of any rules, regulations, standards, or laws governing the Medical Assistance Program, the Medical Division's Provider Review/Sanctions Unit shall transmit a Notice of Violation to the participant by certified mail. The Notice of Violation

shall be sufficiently detailed to afford reasonable notice to the participant of the acts and omissions that the Department alleges constituted such violations. The notice shall describe the sanctions that the Department proposes to impose on account of the alleged violations. If the Department has reason to believe that the violations have resulted in overpayments, the notice shall state the amount of the alleged overpayments, to the extent such amount has been ascertained. The notice may also state whether the matter has been referred by the Department to the Medicaid Fraud Control Unit or any other state or federal agency for criminal investigation, and whether an order for withholding of payments has been made.

450.244: Sanctions: Participant's Reply to Notice of Violation

(A) The participant shall answer the Notice of Violation by written petition not later than 14 days after the date on which the Notice of Violation is delivered or presented for delivery to the participant (or, in case of an election pursuant to Subsections 450.236(B)(3) or (C), the date of mailing of the notice of election). The petition must specifically identify and address all allegations of fact and law with which the participant disagrees, if any, and detail any objections to proposed sanctions. The participant must also include any documentary evidence that he would like the Department to consider in reviewing his petition.

(B) In order to promote clarification of issues and resolution of any or all matters in controversy, the Department may, with the consent of the participant, schedule an informal conference for the purposes of discussing the Notice of Violation and the participant's petition. If the participant wishes to have such a conference, he must so state in his petition.

450.245: Sanctions: Participant's Failure to Reply to Notice of Violation

If the participant fails to reply to the Notice of Violation within the period allowed for reply, the participant shall be deemed to have admitted the allegations contained in the Notice of Violation, including the allegations, if any, respecting the amount of overpayments. The sanctions proposed in the Notice of Violation may be imposed without further notice to the participant.

450.246: Sanctions: Notice of Action

If, after reviewing the participant's petition and, if applicable, after consideration of any evidence or arguments presented at an informal conference, the Department still has reason to believe that the participant has committed one or more violations of any rules, regulations, standards, or laws governing the Medical Assistance Program, the Medical Division's Provider Review/Sanctions Unit shall transmit a Notice of Action to the participant by certified mail. The Notice of Action shall specify any facts relied upon as the basis for the action,

cite the statutes and regulations that enable the Department to take the designated action, and inform the participant of his right to request a formal administrative hearing. It shall also state any proposed sanctions and the amount of overpayments that the Department proposes to recover as a result of the alleged violations.

450.247: Sanctions: Participant's Reply to Notice of Action

The participant shall answer, by Notice of Claim for an Adjudicatory Proceeding, the Notice of Action not later than 21 days after the date on which the Notice of Action is delivered or presented for delivery to the participant. The Notice of Claim shall specifically admit or deny each violation alleged; a general denial shall not constitute an acceptable reply. The Notice of Claim may also contain, in reasonably concise statements, any other matters the participant can offer in rebuttal, avoidance, or explanation of the Department's allegations, including the allegations, if any, respecting the amount of overpayments.

450.248: Sanctions: Participant's Failure to Reply to Notice of Action

If the participant fails to reply to the Notice of Action within the period allowed for reply, the participant shall be deemed to have waived his right to a hearing, and to have admitted the allegations contained in the Notice of Action, including the allegations, if any, respecting the amount of overpayments. The sanctions proposed in the Notice of Action may be imposed without further notice to the participant.

450.249: Sanctions: Extension of Time for Participant's Reply

The Department for good cause shown may at any time in its discretion extend the response times set forth in Sections 450.244 and 450.247 upon the participant's written request.

450.250: Sanctions: Withdrawal of Notice of Action

Whenever the Department decides not to pursue a sanctions proceeding commenced by a Notice of Action, it shall notify the participant through a Withdrawal of Notice of Action. If the Department has determined that the participant has not violated any of the rules, regulations, standards, or laws governing the Medical Assistance Program, the notice shall so indicate.

450.251: Sanctions: Stay of Sanctions pending Hearing

If the participant replies to the Notice of Action in the time and manner specified in Section 450.247, any proposed suspension shall be stayed pending decision after a hearing, except that a suspension need not be stayed if the Department has reason to believe that such a stay would be injurious to the health, safety, or welfare of recipients.

The Department shall schedule a hearing as soon as practicable, but no later than 30 days after a decision not to stay the proposed sanctions, and give notice thereof to the participant; provided, however, that if the matter has been referred to the Medicaid Fraud Control Unit or other criminal investigation agency, the Department may stay the hearing until the conclusion of such investigation and the final disposition of any criminal complaint or indictment that ensues.

450.252: Sanctions: Conference

With the consent of both the participant and the Department, the parties may confer informally and without prejudice prior to the hearing with a view to clarification of issues and resolution of any or all matters in controversy. Such a conference may be held with or without the participation of the hearing officer appointed to hear the case, as the parties may agree.

450.253: Sanctions: Consent Order

At any time subsequent to the transmission of the Notice of Action, the Department and the participant may effect a mutually acceptable resolution of any or all of the matters in controversy. Such acceptable resolution shall be expressed in a written consent order, which shall be signed by the participant and the Department and filed with the Medical Division's Provider Review/Sanctions Unit.

450.254: Sanctions: Hearing

The hearing shall be conducted in accordance with M.G.L. c. 30A, s. 9, 10, and 11. The practice and procedure governing the hearing will be determined by the Formal Rules of the Standard Rules of Practice and Procedure promulgated pursuant to St. 1978, c. 60 and found at 801 CMR 1.00, 1.01, and 1.03, as lawfully modified or supplemented by these regulations. Both the participant and the Department shall have the opportunity to be represented by counsel and to offer evidence and argument with respect to each allegation of the Department as to which the Notice of Action and the participant's reply disclose a dispute as to a material fact or a question of law, and with respect to the appropriateness of the sanctions proposed by the Medical Division's Provider Review/Sanctions Unit. The hearing shall be conducted before a hearing officer who shall be appointed by the Commissioner.

450.255: Sanctions: Hearing Officer's Decision

The decision of the hearing officer shall be in the form of a proposed decision to the Commissioner. The proposed decision shall be written or stated in the record of the hearing. It may affirm, modify, or overturn the sanctions proposed in the Notice of Action. The decision shall include a determination of the extent of overpayments, if overpayments have been alleged. The decision shall be accompanied by a statement of reasons for the decision, including determination of each

issue of fact or law necessary to the decision. The Department shall notify the participant by mail of the decision of the hearing officer.

450.256: Sanctions: Commissioner's Decision

The decision of the Commissioner shall be final. If, prior to the close of the hearing, any party makes a written request for an opportunity to file objections to the hearing officer's proposed decision and to argue in support thereof, the parties shall have seven days from receipt of the decision to make such filing. The Commissioner shall have the discretion to allow or to order the parties to argue orally. In the absence of such a request, the Commissioner may deny the parties any opportunity to file objections. Sanctions shall be imposed in accordance with the Commissioner's decision.

450.257: Sanctions: Notice of Imposition

In appropriate cases, the Department shall give notice of sanctions proceedings and their disposition to professional societies, boards of registration, federal or state agencies, and other law-enforcement agencies.

450.258: Sanctions: Methods of Recovery of Overpayments

If the Department imposes sanctions requiring payment of the money by the participant to the Department under Section 450.242, or if overpayments have been determined under Section 450.236 or in a sanctions proceeding, the Department may effect recovery of such amounts with interest thereon at the same rate applicable to judgments in courts of the Commonwealth by one or any combination of the following methods:

(A) an action to recover the same in any court having jurisdiction;

(B) restitution by the participant in accordance with the final decision or other disposition by the Department in a sanctions proceeding, including a consent order under Section 450.253;

(C) restitution by the participant pursuant to a court order in any criminal proceeding against the participant;

(D) recoupment or set off against other sums due or to become due from the Department to the participant, including sums held by the Department pursuant to an order for the withholding of payments made under Subsection 450.238(B).

(106 CMR 450.259 through 450.260 Reserved)

450.261: Recipient and Provider Fraud

(A) Introduction. Federal regulations require that the Commonwealth of Massachusetts inform providers and recipients of the contents of Section 1909 of Title XIX of the Social Security Act (42 U.S.C. 1396h). This Section 1909 concerns federal penalties for fraudulent acts and false reporting.

(B) 42 U.S.C. 1396h.

"(a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title [Title XIX of the Social Security Act],

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State Plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for

such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) (1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both."

(106 CMR 450.262 through 450.300 Reserved)

450.301: Claims

In general, a claim for a medical service may be submitted only by the provider that furnished the service. Some exceptions and qualifications to the general rule appear in program regulations applicable to specific provider types and in Section 450.331. In the absence of a specific exception or qualification, the following rules shall apply.

(A) An individual practitioner may not claim payment under his own name and provider number for services actually furnished by another individual, whether or not the individual who furnished the service is also a participating provider, or is an associate, partner, or employee of the individual practitioner.

(B) An individual practitioner may not claim payment under his own name and provider number for medical services furnished by him in the course of his employment by a licensed institution or facility (e.g., hospitals, clinics, long term care facilities, pharmacies, home health agencies, health maintenance organizations, community health centers, psychiatric day treatment/day habilitation centers, and adult day care centers), and for which he has received compensation from such employer. In such cases, payment may be claimed only by the licensed institution or facility.

450.302: Claim Forms

Claims must be submitted on the claim form appropriate to the provider type of the submitting provider. The appropriate claim form and the claims-processing center to which it must be submitted are identified in program regulations applicable to that provider type, or in billing instructions furnished to providers by the Department.

450.303: Prior Authorizations

In certain instances, the Department will not process a claim unless the provider has first obtained prior authorization to furnish the medical service for which payment is requested. These instances and procedures for requesting prior authorizations are identified in the program regulations and associated fee schedules.

(A) The Department shall act on requests for prior authorization for medical services within the following time periods.

(1) For transportation to medical services--within seven calendar days after a request for service, except that it shall be the number of days necessary to avoid any serious and imminent risk to the health or safety of the recipient that might arise from the failure of the Department to act until the full seven days.

(2) For private duty nursing services--within 14 calendar days after a request for service.

(3) For durable medical equipment--within 15 calendar days after a request for service, as provided in the Department's regulations governing durable medical equipment.

(4) For all other Medical Assistance Program services--within 21 calendar days after a request for service.

(B) The following rules shall apply in determining the period within which the Department shall act on a request for prior authorization.

(1) A request for prior authorization is made on the date the request is received by the Department, provided that the request is submitted in the manner specified in the relevant program regulations as to form, address for submission, and, except in emergencies, required documentation.

(2) In the event that a provider, acting on behalf of a recipient, makes a request to the Medical Division for prior authorization of a medical service, and the provider is unaware of the verification

requirement or submits a request that does not comply with the relevant program regulations, the provider shall be informed:

(a) of the relevant program regulations governing prior authorization;

(b) that the Department will act on the request within the time limits specified in this section if the required information is received by the Medical Division within four calendar days after the request; and

(c) that if the required information is not submitted within four calendar days, the Department's decision may be delayed by the time elapsing between the four days and when the Department receives the necessary information.

(3) A service is authorized on the date the Department transmits its decision concerning the request for prior authorization to the recipient or someone acting on the recipient's behalf.

(4) In the event that a recipient makes a request for transportation to medical services to a Welfare Service Office, the recipient shall have two calendar days to provide necessary verification to the Welfare Service Office in order for the Department to act on the request within seven calendar days.

450.304: Signature Requirement

Every claim form submitted for payment must be signed by or on behalf of the provider identified on the claim form as the provider that furnished the services claimed. In accordance with M.G.L. c. 118E, s. 20, all claim forms must be signed under the penalties of perjury, except for claims submitted by institutional providers that have entered into a written agreement with the Department as described in that statute. Signature and submission of claim forms by agents are governed by Sections 450.331 through 450.338, relative to billing intermediaries. A provider that accepts payment of a claim shall be presumed to have authorized the signature and submission of the claim on his behalf.

450.305: Tape Exchanges

The Department will permit providers and billing intermediaries, in their behalf, to submit claims by tape exchange. All submissions in this mode shall be presented in such formats and delivered in such manner as the Department may determine in billing instructions that will be made available to all providers and billing intermediaries. In addition, each tape shall be accompanied by a transmittal document that shall state, with respect to each provider's claims that appear on such tape, the number and total dollar sum requested for payment and a signature in accordance with Section 450.304 certifying all claims in the manner required for the claims if they had been submitted upon the appropriate Department claim forms.

450.306: Certification

Signature, whether handwritten or mechanically applied, and submission of a claim form constitute certification of the claims thereon in the manner and with the effect set forth in Subsection 450.223(C)(2). False or erroneous certification of a claim form is a violation of the regulations.

450.307: Unacceptable Billing Practices

(A) The Department forbids the use of any device or stratagem that may have the effect of increasing the total amount claimed or paid for any medical service beyond the maximum allowable amount payable for such service under the applicable rate or fee schedule.

(B) Without limiting the generality of Subsection (A) above, the following billing practices are forbidden:

(1) duplicate billing, overstating or misdescribing services, and similar devices;

(2) submitting claims for services or procedures that are components of a more-comprehensive service for which a specific fee is fixed, when the comprehensive service was the service actually provided; and

(3) submitting claims under an individual practitioner's provider number for services performed by the individual practitioner as an employee of or on behalf of a group, facility, agency, institution, organization, business, or other nonindividual provider.

450.308: Overlapping Fiscal Years

A provider must bill for services furnished in different fiscal years on separate claim forms. A fiscal year encompasses the period from July 1 of a calendar year through June 30 of the following calendar year. If a claim form contains claims for services furnished in two different fiscal years, the Department may reject the entire claim form.

450.309: Time Limitation on Submission of Claims: General Requirements

(A) The period fixed by statute for submission of claims is 90 days (M.G.L. c. 118E, s. 20). The Department measures the 90-day period from the date of service to the date on which the claim form containing the claim for that service is received by the Department. Unless otherwise specifically provided in Sections 450.310 through 450.315, the Department will deny claims received later than the ninetieth day (or such other time period as may be established in accordance with the provisions of Subsection (C) below) following the date on which the claimed service was provided to the recipient, except that the Department may waive said requirement when the failure to submit claims within the 90-day period was caused by mistake, inadvertence, or excusable neglect. The Department shall establish procedures, and notify

providers of same through billing instructions, for claiming a waiver of the 90-day submission requirement with respect to any claim. In no event will the Department process a waiver with respect to any claim received later than one year after the last day of the month of the date of service, or such lesser time as the Department may establish in its billing instructions.

(B) When a service is provided continuously on consecutive dates in a hospital, a nursing home, or an adult day care center, the date from which the 90-day submission period is measured is the latest date in the range of consecutive dates of service.

(C) In the event that the period fixed by statute for submission of claims is changed, the Department may, upon notification to providers through billing instructions, accept for processing claims that are properly submitted within the period as amended by statute.

450.310: Time Limitation on Submission of Claims: Extended Submission Period for Hospitals

If submission of a claim by a hospital is delayed pending completion of a review of the claim by a Professional Standards Review Organization (PSRO) or any other utilization-review organization performing like functions, the claim will be deemed to have been timely submitted if it is received not later than the ninetieth day following the date on which the utilization-review organization certifies the claim, but only if the medical records and other documents necessary for the review were received by the utilization-review organization on or before the ninetieth day following the date of service. The hospital must submit, with the claim form, a dated receipt or other proof that such documents were timely received by the utilization-review organization.

450.311: Time Limitation on Submission of Claims: Retroactive Recipient Eligibility

(A) If a medical service was provided to a person who was not a recipient on the date of service, but who is later enrolled as a recipient for a period that includes the date of service, a claim for such a service will be deemed to have been timely submitted if it is received not later than the ninetieth day following the date of notice to the recipient of the retroactive eligibility determination, but only if satisfactory evidence of the fact and date of such determination is submitted with the claim. For recipients in assistance categories 00, 02, or 04, a photocopy of the notification letter (NFL #4), sent to the recipient by the Welfare Service Office, is satisfactory evidence. For recipients in assistance categories 01 or 03, a photocopy of either the SSI Notice of Award letter or the SSI Notice of Change letter, sent to the recipient by the Social Security Administration, is satisfactory evidence. For recipients in assistance categories 05, 06, 07, or 08, a photocopy of the notification letter (NFL #3), sent to the recipient by the Welfare Service Office, is satisfactory evidence.

(B) If a recipient fails to notify a provider in a timely fashion that a medical service falls within a period covered by a retroactive eligibility determination, such service will not be considered a medical service subject to the provisions of Section 450.203. In the event of timely notification, the provisions of Section 450.203 shall be applicable and the provider shall, upon the recipient's request, immediately return all sums solicited, charged, received, or accepted with respect to such service.

450.312: Time Limitation on Submission of Claims: Retroactive Provider Eligibility

If a medical service is provided to a recipient by a provider who was not a participating provider on the date of service, but who is later enrolled as a provider for a period that includes the date of service, a claim for such service will be deemed to have been timely submitted if it is received on or before the ninetieth day following the date on which the provider becomes a participating provider, but only if the provider's application to become a participating provider is received by the Medical Division not later than the ninetieth day following the date of service. All claims submitted in accordance with this section must be identified in accordance with billing instructions to be provided by the Department.

450.313: Time Limitation on Submission of Claims: Claims for Recipients with Health Insurance

If submission of a claim to the Department is delayed pending compliance with the provisions relative to claims for recipients with health insurance (see Sections 450.316 through 450.319), the claim will be deemed to have been timely submitted if it is received not later than the ninetieth day following the date of the notice of final disposition by the health insurer. (If more than one health insurer is involved, the submission period will be measured from the latest final disposition, and the period for making requests will be measured from the date of the notice of final disposition from the previous insurer.)

450.314: Time Limitation on Submission of Claims: Resubmission of Claims

A claim initially submitted within the applicable limitation period that is partially or fully denied after processing may be resubmitted with appropriate corrections or supporting information. The resubmitted claim must be received not later than the closure deadline as determined by the Department for the fiscal year in which the service was furnished.

450.315: Time Limitation on Submission of Claims: Resubmission of Claims for Prior Fiscal Years

From time to time, the Department may establish and revise procedures and time limits (closure deadlines) for the final resubmission of

unpaid claims previously submitted for medical services furnished by specified provider types for specified fiscal years. In such cases, the Department will give notice thereof to affected providers at the addresses shown in the Department's records at the time of notice. Claims not resubmitted in conformity with such notice shall be denied.

450.316: Third-Party Liability: Introduction

The Department is required to ensure that resources available to the recipient for medical expenses are applied to the cost of medical services furnished under the Medical Assistance Program (see 42 CFR 433.135). Accordingly, the Department requires all providers to make diligent efforts to obtain payment first from health insurers, so that the Department will be the payer of last resort.

450.317: Third-Party Liability: Limitation on Claims for Recipients with Health Insurance

(A) If the recipient's Eligibility Card indicates that a recipient has private health insurance, or is covered by Medicare, or both, a claim to the Department for Medical Assistance Program payment for a medical service that is payable in whole or in part by the private health-insurance company or Medicare will be rejected unless accompanied by a final disposition from each health insurer, including Medicare. The Department will pay only the amount, if any, by which the maximum allowable amount payable by the Department under the applicable rate or fee schedule exceeds the total amount payable by the health insurer or insurers, except where a higher amount is payable under the crossover claims system referred to in Section 450.318.

(B) If the provider is unable to obtain sufficient information from the recipient in order to bill properly health insurers that would make payments directly to the provider for reimbursable services, the provider must contact the recipient's Welfare Service Office in order to obtain the necessary information. In the event that the Welfare Service Office is unable to provide the necessary information, the provider may then submit a claim to the Department. The claim must be accompanied by proof satisfactory to the Department that the Welfare Service Office, at the provider's request, was unable to supply the necessary information, in which event the claim will be processed and paid, if otherwise payable. Such a claim will be deemed to have been timely submitted if it is received not later than the ninetieth day following the date of notification from the Welfare Service Office. In cases in which the provider is able to obtain the name and address of the recipient's health insurer from either the recipient or the recipient's Welfare Service Office, the provider must also submit verification from the health insurer that it would not or was not able to process the claim.

450.318: Third-Party Liability: Special Rules for Medicare

A request for Medicare payment must be addressed to the Medicare fiscal intermediary on the appropriate Social Security Administration (SSA) claim form. The provider must indicate acceptance of assignment on the SSA claim form. In order to secure payment by the Department of the coinsurance and deductible amount (if any), the provider must follow the Department's billing instructions relating to crossover claims.

450.319: Third-Party Liability: Overlapping Insurance Coverage

If the recipient's Eligibility Card indicates that the recipient is covered by more than one health insurer, the provider must make a request for payment to all of them before submitting a claim to the Department. If one of the insurers is Medicare, the first request for payment should be made to Medicare.

450.320: Third-Party Liability: Health Maintenance Organization Coverage

If the recipient's Eligibility Card indicates that the recipient is a member of a health maintenance organization (HMO), the Department will not pay a provider for those medical services that are covered or reimbursed by the HMO. It is the responsibility of the provider to verify the scope of services offered by the HMO.

450.321: Claims Reconsideration for Individual Consideration Medical Services

When a claim for a medical service listed in the fee schedule as an individual consideration (I.C.) item has been totally or partially disallowed by the professional advisory staff of the Medical Division, the provider may request reconsideration of the claim within the time limits specified in Section 450.314. To request reconsideration in such a circumstance, a provider must submit a copy of the remittance advice or claim correction form and substantiation for the reconsideration request to the claims-processing center by which the claim was originally processed. The claims-processing center will retrieve the original claim and documentation and forward them, together with the reconsideration request, to the Medical Division. The reconsideration request will be reviewed by the professional advisory staff, including the Medical Director and excluding the original reviewer of the claim. The professional advisory staff will either confirm the original disallowance or allow an adjustment. The decision of the professional advisory staff shall be final.

450.322: Appeals of Erroneously Denied Claims

Effective October 1, 1979, the Department, by and through a Claims Review Board, will review provider-initiated appeals of claims for services furnished on or after July 1, 1974, but before any fiscal year

for which the closure deadline has not yet occurred, that were mistakenly denied or underpaid as a result of Department error and that cannot otherwise be timely resubmitted. In addition, the Claims Review Board may from time to time initiate reviews designed to discover and to correct denials or underpayments of similar claims. With respect to each such review, the Claims Review Board shall establish the criteria identifying the classes of claims to be reviewed, which criteria may include, but are not limited to, the type of the submitting provider, the time period of initial submission, the service codes for claimed services, and the reasons for initial or subsequent denial.

(A) Providers may submit to the Claims Review Board appeals of claims for services furnished on or after July 1, 1974, but before any fiscal year for which the closure deadline has not yet occurred, only upon the contention that such claims were mistakenly denied or underpaid as a result of Department error and that they cannot otherwise be timely resubmitted. Each appealed claim must be accompanied by the following information and by such other information as the Claims Review Board may request in billing instructions issued to all providers:

(1) a copy of the claim as originally submitted;
(2) evidence of the claim's original, timely submission;
(3) notice of partial or complete denial; and
(4) a statement of reasons why the appeal should be granted.

(B) When it initiates a review, the Claims Review Board will make reasonable efforts to notify all of the affected providers. This notice shall set forth the nature of the review, including any limitations, and explain the process by which providers may appeal the denial of claims determined to have been erroneously denied. Unless otherwise stated in the notice, providers must submit their appeals in accordance with instructions contained therein, which shall require, in addition to such other information as the Claims Review Board deems relevant, that the providers include, for each claim they wish to appeal, the information described in Subsection (A) above.

(C) The Claims Review Board shall review each appeal that is properly, and in the case of a review initiated by the Claim Review Board, timely submitted and that otherwise conforms to the requirements and limitations set forth in the notice reserving the right to reject those claims that do not conform to the applicable criteria. The Claims Review Board shall notify all providers in writing of its decisions regarding disposition of their appeals.

(D) In certain circumstances, such as an unexpectedly high volume of claims or insufficient appropriations, the Claims Review Board may, in its discretion, propose summary disposition of classes of appeals by resorting to statistical sampling, pro rata adjustment, or similar devices, when such methods are not otherwise in violation of any of the rules, regulations, standards, or laws governing the Medical Assistance Program. In such event, affected providers will be notified of the application of these methods and be given an opportunity to accept or

to reject them. By accepting them, providers will be deemed to have accepted the disposition of their appeals in accordance with the methods as full and complete discharge of their claims adjudicated by the Claims Review Board. Should the methods be rejected, all affected claims will be returned to the providers without further processing.

(E) In some cases, the Department will be able to identify claims that it erroneously denied in part or in whole. In such instances, the Claims Review Board may, on its own motion, establish the validity of such claims and invoke the appeals procedure on behalf of affected providers, following which the Claims Review Board will notify the affected providers in writing of its disposition of those appeals.

(F) The Claims Review Board shall have the authority, upon 30 days' notice to all providers, to change current criteria or to issue new criteria governing the dates and types of claims that providers may appeal.

(G) Providers reserve the right to decline to participate in the administrative processes described in this section. There shall be no further administrative remedies beyond the Claims Review Board. By participating or refusing to participate, providers shall not be deemed to have waived their remedies, if any, at law.

450.323: Payment of Claims

Except as otherwise provided in Section 450.331, payment checks for submitted claims shall be payable only to the contractor that has entered into a provider agreement on behalf of the provider in whose name the claims were submitted.

(106 CMR 450.324 through 450.330 Reserved)

450.331: Billing Intermediaries: Introduction

(A) For the convenience of contractors, the Department will process claims that are submitted through authorized billing intermediaries (either billing agencies or group practice organizations). At the written request of a contractor, the Department may also mail remittance advices to a billing intermediary to aid in the reconciliation of accounts. In the case of an authorized group practice organization that handles all receipts in a central account and makes disbursements to member providers from that account, the payment check will be issued to the group practice organization, and the payment will be reported to the Internal Revenue Service as income of the group practice organization. In the case of an authorized billing agency, the payment check will be issued to the contractor with whom the Department has contracted for the services of the provider for whom the claim is submitted. The Department will not issue checks to billing agencies, but will, at the written request of a contractor, deliver checks payable to the contractor to the billing agency.

(B) The Department recognizes a billing intermediary solely and strictly as the provider's agent. A billing agency or group practice is not a "provider". The Department's recognition of the intermediary relationship does not relieve a provider of any responsibility imposed on him elsewhere in these regulations for the claims that he submits or that are submitted on his behalf. Intermediary billing arrangements present some potential for abuse, of the provider as well as the Department. These regulations are intended to limit that abuse potential as much as possible. However, in leaving his financial affairs in the hands of others, a provider must exercise sufficient supervision to ensure that he does not become an unwitting participant in improper billing practices. In any case, a provider will be held personally accountable for his agent's actions.

450.332: Billing Intermediaries: Authorization Requirements

In order to receive authorization to serve as a billing intermediary for participating providers, a billing agency or group practice organization must meet the following requirements.

(A) It must be a recognized legal entity (either individual, partnership, corporation, or trust).

(B) It must not be currently under a suspension of authorization due to violations of the laws, rules, or regulations governing the Medical Assistance Program. The Department may also deny an application for authorization of any billing intermediary that has common parties in interest with any provider or with any billing intermediary that is currently under suspension, if such common parties in interest own 50 percent or more of the beneficial interest in both the applicant and the suspended provider or billing intermediary.

(C) No billing intermediary shall be eligible to receive authorization if it, any party in interest in it, or its managing employees or agents as those terms are defined in Section 450.221 have been convicted of a crime of such a nature that, in the judgment of the Department, its authorization would compromise the integrity of the Medical Assistance Program.

(D) In order to be eligible to receive authorization as a group practice organization, the applicant must additionally satisfy one of the following:

(1) all of the beneficial interest in the group practice organization must be held by individual practitioners who are members of the group practice served by the group practice organization; or

(2) all members of the group practice must be employees or contractors of the group practice organization.

450.333: Billing Intermediaries: Application for Authorization

Any billing agency or group practice organization desiring to receive authorization to serve as a billing intermediary for providers shall file an application with the Medical Division. The application shall be deemed to be a part of any billing agency agreement or group practice agreement that ensues, and any material omission or misstatement therein shall (without limiting any other penalties or sanctions resulting therefrom) render such agreement voidable by the Department. The application shall contain the following information (with the term "applicant" referring to the billing agency or group practice organization filing the application):

(A) the applicant's name and address;

(B) identification of the applicant as an individual, corporation, trust, or partnership;

(C) the applicant's Federal Employer Identification Number;

(D) the name and address of each party in interest in the applicant, and the percentage of beneficial interest in the applicant owned by each party in interest;

(E) the identity of any person who:
(1) has an ownership or control interest in the billing intermediary or is an agent or managing employee of the billing intermediary as those terms are defined in Section 450.221; and
(2) has been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid, or the social services program under Title XX of the Social Security Act;

(F) the name, address, and provider number of every participating provider in which the applicant has a beneficial interest; and

(G) such other information as the Department may require.

450.334: Billing Intermediaries: Execution of Authorization Agreement

(A) If the billing agency or group practice organization seeking authorization to serve as a billing intermediary for participating providers has filed a complete and properly executed application, and nothing in the application or any other information in the possession of the Department reveals any bar or hindrance to the authorization of the applicant as a billing intermediary, the Department shall prepare and furnish an authorization agreement as soon as possible that, when fully executed by the applicant and the Department, shall take effect as of the effective date stated in the authorization agreement. In its discretion, the Department may prepare and furnish application blanks in such form that the completed application itself, when countersigned by the Department and delivered to the applicant, shall constitute the

authorization agreement. Upon execution of the agreement, the Department will issue an identification number to the billing intermediary. No billing intermediary shall have or use more than one such identification number.

(B) Each authorized billing intermediary shall forthwith notify the Department of any material change in any of the information submitted in the application form, and failure to do so shall constitute a breach of the authorization agreement. In its discretion, the Department may require authorized billing intermediaries to recertify, at reasonable intervals, the continued accuracy and completeness of the information contained in the billing intermediary's application, but no failure by the Department to require recertification shall relieve the billing intermediary's obligation under the first sentence of this subsection.

(C) The following provisions shall be a part of every authorization agreement, whether or not they are included verbatim or specifically incorporated by reference.

(1) The billing intermediary agrees to comply with all laws, rules, and regulations governing the Medical Assistance Program that are applicable to it.

(2) The billing intermediary agrees not to submit any claim to the Department on behalf of any provider if the billing intermediary has knowledge that such claim is submitted in violation of a law, rule, or regulation applicable to the provider for whom the claim was submitted, or in violation of such provider's agreement with the Department.

(3) The billing intermediary agrees to preserve, in original form, all information supplied by providers that was employed by the billing intermediary in preparing claims for submission to the Department, and all financial and other records relating to its dealings with participating providers, and agrees to retain such information and records for not less than four years after payment of the claim to which it relates or, with respect to any provider, for such length of time as dictated by the provisions of Section 450.205, whichever time period is longer, and to give authorized Department representatives access to such records upon reasonable request at all reasonable times.

(4) This agreement may be terminated by the Department if the billing intermediary shall fail or cease to satisfy all applicable criteria for authorization to serve as a billing intermediary for participating providers.

450.335: Billing Intermediaries: Provider Responsibilities

(A) No provider shall utilize the services of any person, business, or organization, other than an employee of the provider, for the preparation and submission of claims to the Department for services reimbursable under the Medical Assistance Program, unless that person, business, or organization is an authorized billing agency or an authorized group practice organization.

(B) Any provider that engages a billing intermediary for the preparation and submission of claims to the Department is fully responsible to the Department for all acts by such billing intermediary with actual or apparent authority to perform such acts, notwithstanding any contrary provisions in any agreement between the provider and the billing intermediary. In case of any violations of laws, rules, or regulations, or of the provider agreement arising out of the acts of the billing intermediary, the provider shall be fully liable as though they were the provider's own acts.

(C) A provider intending to utilize the services of a billing intermediary for the preparation and submission of claims to the Department for services reimbursable under the Medical Assistance Program shall, prior to the commencement of such services, execute an "appointment of billing intermediary", in such form as the Department may prescribe, and deliver it to the Medical Division. On this form, the provider shall indicate whether he chooses to have remittance advices and checks forwarded to himself or to the billing intermediary. The Department will furnish such forms to billing agents, group practice organizations, and providers on request.

(D) A provider intending to terminate a relationship with a billing agency or group practice organization shall notify the Medical Division at least ten days prior to the effective date of such termination. The provider shall remain responsible for any acts of the billing intermediary within the scope of its actual or apparent authority until the tenth day following the Department's receipt of the notice, or the effective date of the termination, whichever is later.

(E) Notwithstanding the appointment of a billing intermediary, a provider must personally execute any provider application or provider agreement.

(F) A provider employing the services of a billing agency shall ensure that the relationship established complies with the requirements of Subsection 450.336(A).

450.336: Billing Intermediaries: Relationships of Billing Agency and Provider

This section is not applicable to group practice organizations.

(A) Pursuant to federal regulation (42 CFR 447.10), no provider that is reimbursed on a fee-for-service basis shall enter into any contract with a billing agency whereby the provider receives financial advances from the agency prior to receipt of Medical Assistance Program payment (the arrangement commonly known as "factoring"). No provider that is reimbursed on a fee-for-service basis shall reimburse a billing agency for the agency's service on any basis that is related directly or indirectly to the dollar amounts to be billed or collected, if such billing agency is given any form of control, by power of attorney, assignment, or otherwise, over payments received by the provider.

(B) Any provider that employs the services of a billing agency for the processing of claims to the Department for services reimbursable under the Medical Assistance Program must enter into a written contractual agreement with that billing agency that must contain at least the following provisions:

(1) a description of the services to be performed and the payments to be made under the agreement;

(2) a statement of the effective and expiration dates of the agreement, and the manner in which such agreement may be terminated and extended;

(3) delegation by the provider to the billing agency of authority to sign for the provider on claim forms submitted for payment if the billing agency is to sign claim forms;

(4) acknowledgement by both parties that all information, representations, and certifications appearing on claim forms submitted by the billing agency are to be relied on by the Department as having been made on the provider's behalf and with the provider's authority until such authority has been revoked by the provider in accordance with these regulations;

(5) representation by the provider that the provider is presently enrolled with the Department as a participating provider in the Medical Assistance Program, and by the billing agency that it is authorized by the Department to serve as a billing agency for participating providers, each party reciting the identification number assigned to it by the Department;

(6) representation by both parties that they are aware of the federal regulation referred to in Subsection 450.336(A), and agree to abide by same; and

(7) acknowledgement that either party will, upon the Department's request, forward a copy of the agreement to the Department.

450.337: Billing Intermediaries: Processing of Claims through a Billing Intermediary

(A) Any claim submitted through a billing intermediary shall show, in addition to the provider number of the provider making the claim, the identification number of the billing intermediary.

(B) If so specified in the "appointment of billing intermediary" (see Subsection 450.335(C)), the Department will mail remittance advices, identifying the disposition of specific claims, and checks payable to the contractor directly to the billing intermediary.

(C) The privilege of submitting claims through a group practice organization is limited to individual practitioners who are members of the group practice served by the group practice organization that prepares and submits the claims.

(D) All claims submitted through a group practice organization must clearly identify by provider number the member or employee of the group practice who actually furnished the services being claimed.

450.338: Billing Intermediaries: Sanctions

Any billing agency or group practice organization that is determined to have knowingly caused or acquiesced in the submission of incorrect or incomplete claims, or otherwise violated the laws, rules, or regulations applicable to the Medical Assistance Program or the terms of its authorization agreement with the Department, shall be subject to administrative action, and shall be liable to the Commonwealth for any financial loss or damage to the Department that may result. The procedures of Sections 450.234 through 450.258, modified as necessary to apply to billing intermediaries, shall apply generally in proceedings for the application of sanctions under this section.

REGULATORY AUTHORITY

106 CMR 450.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

DEPARTMENT OF PUBLIC WELFARE

MEDICAL ASSISTANCE PROGRAM

The Commonwealth of Massachusetts Department of Public Welfare .....

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LEVEL-OF-CARE CRITERIA

456.251: Introduction

(A) The regulations in Sections 456.252 through 456.270 establish minimum medical criteria for determining a recipient's need for skilled nursing facility or intermediate care facility services provided under the Medical Assistance Program. These regulations also establish psychosocial criteria that, when present, could indicate the need for a recipient to remain in a skilled nursing facility or intermediate care facility.

(B) The Department will approve payment for skilled nursing or intermediate care facility services for only those recipients who meet the level-of-care or psychosocial criteria in Sections 456.252 through 456.270 and who cannot receive the needed care and services in a noninstitutional setting.

(C) Documentation in the recipient's medical record required by these regulations is in addition to any other recordkeeping requirements of the Department and the Massachusetts Department of Public Health.

456.252: Definition of Skilled Services

A skilled service is a nursing, rehabilitative, therapeutic, or other medical or medically related service that must be provided either directly by or under the general supervision of a registered nurse or licensed therapist. The Department pays for skilled services only when these services are necessary to prevent physical deterioration or to maintain existing functional capacities. Skilled services must be provided in an institutional setting because of the intensity, length of time, or frequency that they are needed.

456.253: Skilled Nursing Facility Services: Level-of-Care Criteria

To be eligible for skilled nursing facility services, a recipient must meet the criteria in either Subsection (A) or (B) below and must require these services in an institutional setting.

(A) The recipient has been deemed ineligible for Medicare benefits but requires skilled nursing or rehabilitation services as specified in 42 CFR 405.127 and must, because of his physical condition, receive those services in a skilled nursing facility.

(B) The recipient requires one of the following:
(1) skilled nursing services seven days a week;
(2) skilled rehabilitation services five days a week; or
(3) a combination of different skilled services on different days, but at least one skilled service every day.

456.254: Skilled Nursing Services

Skilled nursing services include, but are not limited to, the following:

(A) nursing observation and care for a recipient's unstable or complex medical condition (for example, brittle diabetes or blood dyscrasia);

(B) administration of oral or injectable medications that require the judgment and direction of a registered nurse to monitor the dosage and frequency and to observe the recipient for any adverse reactions to the medication. Drugs with life-threatening side effects, given as treatment for an acute condition, may require skilled nursing care. Administration of the same drug, given in a reduced dosage as a maintenance regimen, does not, in itself, indicate the need for skilled nursing care, nor does a 24-hour medication regimen;

(C) nasopharyngeal aspiration and tracheotomy care; however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled nursing services;

(D) levin tube and gastrostomy feedings;

(E) administration of parenteral solutions on a regular and continuous basis;

(F) care of a colostomy either during an early postoperative period when related medical complications are present or when provided in combination with colostomy training. General continuous maintenance care of a colostomy can usually be performed by the patient himself or by a person without skilled training and, therefore, does not, in itself, indicate the need for skilled nursing services;

(G) care of a suprapubic catheter or care of a urethral catheter when the insertion and maintenance of the urethral catheter is part of an active treatment for a disease of the urinary tract and irrigation is required for medical reasons (for example, when a recipient has cancer of the bladder or a resistant bladder infection).
(1) When care of a urethral catheter is the basis for

recommending or approving the need for skilled nursing care, the urethral catheter must be prescribed by a physician and the need for the catheter must be documented in the recipient's medical record.
(2) The presence of a urethral catheter, particularly one placed for convenience, for the control of incontinence, or for routine irrigation, does not, in itself, indicate the need for skilled nursing care.
(3) For the purposes of this subsection, a urinary tract infection caused by the use of a catheter does not constitute a disease condition;

(H) administration of oxygen or other medical gases when they are needed on a regular and continuing basis because of the recipient's medical condition (for example, when the recipient has chronic obstructive pulmonary disease or pulmonary edema); and

(I) treatment of deep decubitus ulcers (deep area with or without necrotic tissue) or deep skin lesions when the physician has prescribed irrigation or the application of medication or sterile dressings. Infected skin lesions may require skilled nursing care to prevent the spread of the infection to other patients. When care of infected skin lesions is the basis for recommending or approving the need for skilled nursing care, the need must be documented in the recipient's medical record.

456.255: Skilled Rehabilitation Services

Skilled rehabilitation services must be provided as part of an integrated program of medical care, restorative services, and special therapy that includes physical therapy, occupational therapy, speech therapy, and audiology services. These services must be prescribed by a physician. Skilled rehabilitation services include, but are not limited to, the following:

(A) ongoing assessment of a recipient's rehabilitation needs that is performed concurrently with the management of a patient care plan and that is based on tests or measurements of range of motion, strength, balance, coordination, endurance, functional ability, dependence in activities of daily living, perception, speech, language, and hearing;

(B) exercises or activities that are designed to restore, maintain, or improve mental or physical functional ability and that must be performed by or under the supervision of a qualified physical or occupational therapist to ensure the safety of the recipient and the effectiveness of the treatment;

(C) range-of-motion exercises that are part of a planned program of care that includes skilled nursing care and that are a prescribed treatment for a specific condition that has resulted in a loss or restriction of mobility. The degree of motion lost and the motion restoration goals of the treatment program must be specified in the recipient's medical record;

(D) therapy that is provided as part of a planned program of care that includes skilled nursing and a therapy program designed, established, and directed by a qualified therapist. The findings of an initial evaluation and of periodic reassessments of the recipient must be included in the recipient's medical record;

(E) administration of a hot pack, a hydrocollator, infrared treatment, a paraffin bath, or whirlpool treatments when the recipient's primary diagnosed condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or fractures; and

(F) speech therapy or audiology services within the facility when such services are needed for the improvement of the recipient's speech or hearing.

456.256: Other Skilled Services

(A) Skilled Management of an Aggregate of Services.
(1) A recipient may need skilled nursing facility services if his medical condition is such that his recovery or safety can be ensured only if the total care given to him is planned, managed, and evaluated by a registered nurse.
(2) In cases where a recipient's full recovery or improvement is not possible, skilled care may be needed to prevent further deterioration of the recipient's condition.
(3) When the recipient is recommended or approved for skilled nursing facility services under the criteria in this subsection, the recipient's medical record must clearly indicate the reasons that skilled management of those services is required.

(B) Skilled Planning, Management, and Evaluation of the Recipient's Care Plan. A recipient may require skilled nursing facility services if his care plan must be planned, managed, and evaluated by licensed personnel to promote his recovery and to ensure his medical safety because he requires assistance in all activities of daily living, including the following:

(1) transferring: the recipient must be a bed patient who cannot be transferred, must be lifted to be transferred, or must require the physical assistance of another person to be transferred;

(2) walking or wheeling: the recipient must be unable to walk or must require the assistance of another person, with or without mechanical assistance;

(3) bathing: the recipient must be unable to bathe himself;

(4) dressing: the recipient must be unable to dress himself or cannot be dressed because he is bedridden; and

(5) bladder or bowel function: the recipient must be incontinent of bladder or bowel function day and night, or he must require scheduling assistance with bladder or bowel continence, or both. For the purposes of this subsection, incontinence shall also mean that the recipient cannot self-toilet at any time.

(106 CMR 456.257 through 456.259 Reserved)

456.260: Intermediate Care Facility Services: Level-of-Care Criteria

To be eligible for intermediate care facility services, a recipient must meet the following criteria and must require these services in an institutional setting:

(A) he has a medical or mental dysfunction that requires nursing care and services to meet medical or psychosocial needs. The dysfunction may involve one or more physiological systems and may not necessarily be stabilized; and

(B) he requires one of the following:

(1) skilled services on a infrequent basis (that is, less than seven days per week);

(2) restorative services;

(3) assistance in any activities of daily living; or

(4) other intermediate care services.

456.261: Restorative Services

Restorative services must be required to achieve maximum use of physical or mental capabilities, to prevent physical or

mental deterioration, or to maintain optimal functioning. The recipient must require these services in an institutional setting because of the intensity, duration, or frequency of need for the services, the lack of appropriate community services to meet those needs, or both. Restorative services include, but are not limited to, the following:

(A) management of orthotic or prosthetic devices such as casts, braces, or splints. The presence of an orthotic or prosthetic device does not usually require skilled nursing care. If there are other related medical conditions or specific medical complications that necessitate skilled care, these conditions or complications must be documented in the recipient's medical record;

(B) proper positioning in bed or in a wheelchair, changing of position, or other such care to prevent deformity and decubitus ulcers;

(C) prevention of skin irritation and decubitus ulcers including the provision of prophylactic and palliative skin care, such as bathing and the application of creams and lotions. The prevention of skin irritation and decubitus ulcers in some recipients may require skilled nursing care. If it is determined that skilled nursing care is required, documentation of that need must appear in the recipient's medical record;

(D) treatment of skin irritations, small superficial lesions, or superficial decubitus ulcers (reddened area with or without a superficial break in skin);

(E) routine changing of dressings that requires nursing care or direction; and

(F) range-of-motion exercises that are part of a routine maintenance program to prevent contractures and to maintain mobility.

456.262: Assistance in Activities of Daily Living

A recipient may require care in an intermediate care facility if he needs assistance in any activities of daily living. A recipient whose only need is for 24-hour supervision is not appropriate for care in an intermediate care facility. Assistance in activities of daily living includes, but is not limited to, the following services:

(A) provision of training in any activity of daily living in order to improve or maintain the recipient's functional level;

(B) assistance in transferring (for example, from a bed to a wheelchair, from a wheelchair to a commode, or from a bed to a chair);

(C) assistance in the use of a cane, a walker, or other such devices. A restorative or maintenance program that is prescribed or developed by a physician or a physical therapist can be conducted in an intermediate care facility;

(D) assistance in bathing, dressing, and grooming;

(E) provision of special diets with continuous supervision to maintain good nutrition and to prevent nutritional deficiencies. The inability to feed oneself or the need for assistance with eating does not, in itself, indicate the need for intermediate care facility services; and

(F) care or training, or both, in bladder and bowel function, such as the routine care of an indwelling catheter, implementation of a time-control program for bladder and bowel incontinence, or maintenance care of an uncomplicated and regulated colostomy or ileostomy.

456.263: Other Intermediate Care Facility Services

Other services that, if needed, may necessitate care in an intermediate care facility include, and ordinarily are limited to, the following:

(A) monitoring of vital signs and recording of the observations in the recipient's medical record;

(B) application of topical, oral, or certain injectable medications. Injectable medications should be administered either by the recipient under supervision or by a licensed nurse;

(C) application or supervision of the use of palliative treatments using devices such as a whirlpool or a hydrocollator;

(D) routine administration of oxygen when a regimen of use has been prescribed by a physician and when proper oxygen storage is available in accordance with the conditions outlined by the Massachusetts Department of Public Health in its "Rules and Regulations for the Licensing of Long-Term Care Facilities" (105 CMR 150.000);

(E) intermittent use of positive pressure breathing equipment and nebulizers when a stable regimen has been established for conditions such as chronic asthma or emphysema;

(F) use of protective restraints, bed rails, binders, poseys, or other supports when ordered by the recipient's physician and when provided in accordance with written patient-care policies and procedures and a written care plan; and

(G) assistance to a recipient who has a self-care tracheotomy.

(106 CMR 456.264 Reserved)

456.265: Special Circumstances

(A) Sensory Impairment. Sensory loss or impairment is not, in itself, an indication that the recipient requires care in an institutional setting, nor does it indicate the need for a specific level of care. In determining the appropriate care site and the appropriate level of care for a recipient, sensory impairment must be considered with all other factors that indicate the amount, duration, and scope of services necessary.

(B) Mental State Impairment. A recipient who exhibits mental state impairment such as confusion, disorientation in time, place, or person, memory loss, or defective judgment may require care in an institutional setting. However, mental state impairment is not, in itself, an indication that the recipient requires care in an institutional setting, nor does it indicate the need for a specific level of care. In determining the appropriate care for a recipient, mental state impairment must be considered with all other factors that indicate the amount, duration, and scope of services necessary. If a transfer to a higher level of care is recommended for a recipient in an intermediate care facility because of mental state impairment or because the recipient exhibits behavior that is detrimental to himself or to others, the recipient's medical record must contain a written report of a medical examination by a physician and a psychiatric evaluation by a psychologist that documents that the recipient cannot be managed in an intermediate care facility or a noninstitutional setting.

(C) Pacemaker. The presence of a pacemaker may indicate the need for intermediate care facility or skilled nursing facility services; however, it is not, in itself, a sufficient reason for recommending these services. If intermediate care facility or skilled nursing facility services are recommended for a recipient with a pacemaker, the need for such care must be documented in the recipient's medical record.

(106 CMR 456.266 through 456.269 Reserved)

456.270: Psychosocial Criteria

When a recipient is determined according to the Department's level-of-care criteria to be inappropriately placed in a skilled nursing or intermediate care facility, certain factors must exist to justify continued stay at an otherwise inappropriate level of care. These factors are listed below. They are not intended to supersede the level-of-care criteria. They shall not be used in determining the placement of a recipient on admission. They shall be used in justifying a continued stay at an inappropriate level only when it is documented in the recipient's medical record that in the opinion of a licensed medical practitioner a specified criterion or combination of specified criteria would cause the recipient severe harm in the event of a transfer. The requirement for documentation applies to all cases in which a continued stay at an inappropriate level is considered justified and is supplementary to any specific documentation requirements stated as a condition for the application of any particular factor listed below.

(A) Spouse Shares Room. Continued stay may be justified if spouses who share a room do not want to be separated. If only one spouse requires a different level of care, consideration should be given to a transfer to, or continued stay at, the higher level of care. If it is determined that both spouses are at an inappropriate level of care, maintaining the shared-room arrangement should be an important consideration in determining whether to recommend a transfer.

(B) Language Environment. If the recipient's communication skill in the English language is significantly limited and if current placement provides a compatible language environment that would not be available if the recipient was transferred to another facility, this may be a consideration when determining whether to recommend a transfer. However, if the transfer would be to a different level of care within the same facility, the language factor shall not be considered.

(C) Religious Dietary Environment. If the recipient's religious beliefs include dietary restrictions or dictates that are being met in the current facility and that could not be met if the recipient was transferred to another facility, this may be a consideration when determining whether to recommend a transfer. However, if the transfer would be to a different level of care within the same facility, the religious dietary factor shall not be considered.

(D) Frailty and Advanced Age. If the recipient is of advanced age and is diagnosed by his physician as physically frail, transfer may not be indicated if the recipient has resided in the facility for three or more years and if there is a documented history of adjustment problems and poor mental health status evidenced by such factors as chronic depression, social withdrawal, inappropriate hostility, verbally abusive behavior, or severe lethargy. If this factor is to be applied, there must be documentation in the recipient's medical record by the attending physician verifying that the recipient would be at risk medically if a transfer occurred.

(E) Mental Health Status. If the recipient has exhibited unstable behavior or adjustment problems, has recently lost a relative, or is participating in an organized treatment program to maintain or improve his mental health status, a decision to transfer him may be delayed for 30 days. During this time, if a licensed or certified mental health professional documents in the recipient's medical record that in his opinion a transfer will be harmful to the recipient's mental health, continued stay may be justified.

(F) Blindness. Although a recipient's blindness is not, in itself, a sufficient reason for not transferring him, it should be considered with all other factors involved in the transfer and in relation to the recipient's medical and psychosocial needs.

(G) Loss of Visitors. If the recipient is visited often and regularly by one or more relatives or friends and the location of the alternative facility would make it impossible for those relatives or friends to arrange public or private transportation to continue those visits, continued stay may be justified if there are no other relatives or friends who could visit him in the new location. If this factor is applied, the standard used must be the impossibility of continued visits, not merely inconvenience to the relatives or friends.

REIMBURSABLE DAYS: MEDICAL ABSENCES FROM LONG TERM CARE FACILITIES

456.511 Introduction

In order to minimize the physical and emotional stress when the relocation of infirm patients from one long term care facility to another is necessitated, the Department will pay to reserve beds in Level I, Level II, and Level III facilities for Medical Assistance recipients during brief absences for the purpose of obtaining acute hospital care.

456.512 Definitions

Reference is made to 106 CMR 450.101 (the Medical Assistance Program Administrative Regulations, formerly the "Introduction" and "Section A" of Chapter VII of the Massachusetts Public Assistance Policy Manual), which defines common words and expressions appearing in the Department's regulations relative to the Medical Assistance Program. In addition, the following words and expressions used in these Sections 456.511 through 456.516 shall have the meaning given in this section unless the context clearly requires a different meaning. Words set in SOLID CAPS are defined elsewhere in this list or in 106 CMR 450.101.

(A) Medical Absence -- an absence from a long term care facility that commences on the day a RECIPIENT is transferred to an acute care hospital. The day on which a RECIPIENT is transferred from an acute care hospital back to the long term care facility is not considered to be a day of medical absence.

(B) PSRO Utilization Review Coordinator -- the individual responsible for Professional Standards Review Organization review in a hospital.

(C) Working Days -- Monday through Friday except for legal holidays and other official interruptions of the work week.

456.513 Conditions of Payment

The conditions of payment specified in these regulations shall apply to all acute care hospital admissions of all recipients residing in long term care facilities, regardless of the duration of the recipient's residence in the facility, so long as the hospital or unit to which the recipient is admitted is included in the Professional Standards Review Organization (PSRO) Utilization Review system.

(A) The Department will not pay to reserve a bed in a facility during a recipient's hospital stay when the hospitalization occurs in any hospital other than an acute care hospital or unit included in the PSRO Utilization Review system.

(B) The Department will pay to reserve a bed in a facility during a recipient's hospital stay, commencing on the day on which the recipient is transferred from the facility to a hospital, until such time as the PSRO Utilization Review coordinator notifies the facility of the estimate of the recipient's length of stay in the hospital.

(C) The Department will pay to reserve a bed in a facility for up to ten days if the PSRO Utilization Review coordinator indicates that the estimated length of stay of the recipient in the hospital will be ten days or less. The PSRO Utilization Review coordinator may later change the estimate of the length of stay. If the revised estimate exceeds ten days, the Department will not pay to reserve the bed on and after the date on which the PSRO Utilization Review coordinator notifies the facility of the new estimate.

(D) The Department will not pay to reserve a bed in a facility on and after the date on which the PSRO Utilization Review coordinator notifies the facility that the estimated length of stay of the recipient in the hospital will exceed ten days. The PSRO Utilization Review coordinator may later change the estimate of the length of stay. If the revised estimate is ten days or less, the Department will pay to reserve the bed on and after the date on which the PSRO Utilization Review coordinator notifies the facility of the revised estimate. However, the Department will pay to reserve a bed only if it is empty at the time the PSRO Utilization Review coordinator notifies the facility of the revised estimate.

(E) The Department will not pay to reserve a bed in a facility for more than ten days for any given acute care hospital stay, regardless of the estimated length of stay made by the PSRO Utilization Review coordinator.

456.514 Responsibility of the Long Term Care Facility in Recipient Transfers to an Acute Care Hospital

(A) If the conditions listed in Section 456.513 apply, the long term care facility must reserve the recipient's bed for up to ten days unless one of the following conditions applies:

(1) the recipient does not wish to return to the facility and has so stated in writing or through communication with his guardian, conservator, relative, sponsor, friend, physician, or if none of the preceding exists, by an individual affiliated with the facility who shall sign a statement to this effect. Such written statements shall become part of the recipient's medical record in the long term care facility; or

(2) the recipient's physician determines that the recipient will require a different level of care upon discharge from the hospital, and no bed at the appropriate level of care is available at the original facility. The physician must document this in the recipient's medical record in the hospital.

(B) When a recipient is transferred from a facility to an acute care hospital, the administrator of the facility must ensure that:

(1) the date and time of transfer are documented in the recipient's record;

(2) the appropriate portion of the Department's Long Term Care Bed Reservation Form (LTC-1) is completed and sent to the hospital with the recipient in an envelope labeled "Attention PSRO Utilization Review Office". In an emergency, the form must be forwarded to the hospital PSRO Utilization Review Office within 24 hours of the recipient's admission to the hospital; and

(3) the recipient's bed will be automatically reserved until the facility is notified via telephone of the PSRO Utilization Review coordinator's estimate of length of the hospital stay.

456.515 Responsibility of the PSRO Utilization Review Coordinator and the Acute Care Hospital in Recipient Transfers

(A) When a recipient who is a resident in a long term care facility enters an acute care hospital, the following procedures shall apply:

(1) Upon the recipient's arrival at the hospital, the bed reservation form shall be forwarded immediately to the PSRO Utilization Review coordinator.

(2) The PSRO Utilization Review coordinator will review the recipient's medical record according to PSRO review criteria not later than the third working day of the recipient's hospital stay.

(3) When the PSRO review indicates that the expected length of stay of the recipient will be ten days or less, the PSRO Utilization Review coordinator shall immediately notify the facility by telephone of the estimated length of stay, and the facility shall reserve a bed for the appropriate number of days up to a maximum of ten. The coordinator shall also notify the hospital's discharge planning unit that a bed has been reserved for the recipient.

(4) When the PSRO review indicates that the expected length of stay will exceed ten days, the PSRO Utilization Review coordinator shall immediately notify the facility by telephone that a bed should no longer be reserved for the recipient as of the date of notification. The coordinator shall also notify the hospital's discharge planning unit that a bed has not been reserved for the recipient.

(5) After the PSRO Utilization Review coordinator notifies the facility by telephone as to whether or not to reserve a bed, he shall:

(a) complete the Bed Reservation Form, clearly noting the date of the telephone notification to the facility;

(b) retain the completed form for up to ten days from the date of the recipient's hospital admission;

(c) after the ten-day period has expired, send a copy of the completed form to the facility for placement in the recipient's record;

(d) retain a copy of the completed form for his files;

(e) forward a copy of the completed form to the hospital's social services office or equivalent; and

(f) send the original of the form to the Long Term Care Unit, Medical Division, 600 Washington Street, Room 740, Boston, MA 02111.

(6) The PSRO Utilization Review coordinator, physician advisor, or PSRO office staff are the only individuals authorized to contact the facility to approve or to disapprove a bed reservation reimbursable under this regulation. Notification from the PSRO Utilization Review coordinator shall take precedence over any conflicting notifications from such other sources as the attending physician or a family member or friend of the recipient.

(B) If a change in the recipient's medical status occurs on or before the tenth day of the hospital stay, the PSRO Utilization Review coordinator may change the estimate of the length of stay.

(1) If the PSRO Utilization Review coordinator originally indicated that the length of stay would exceed ten days and later indicates that the length of stay will be ten days or less, the coordinator shall authorize a bed reservation by:

(a) notifying the facility by telephone of the new estimate of the length of stay and reserving a bed in the facility up to the tenth day of absence from the facility; and

(b) 1. if a bed is available, noting the change in the recipient's status and the date of notification to the facility on the Bed Reservation Form in the portion labelled "Redetermination" and notifying the hospital's discharge planning unit that a bed is reserved for the recipient; or

2. if a bed is not available, following the procedure detailed in Section 456.515(A)(5).

(2) If the PSRO Utilization Review coordinator originally indicated that the length of stay would be ten days or less and later indicates that the length of stay will exceed ten days, the coordinator shall terminate the bed reservation by:

(a) notifying the facility by telephone that a bed should no longer be reserved for the recipient as of the date of the telephone notification; and

(b) noting the change in the recipient's status and the date on which the facility was notified on the Bed Reservation Form in the portion labelled "Redetermination" and notifying the hospital's discharge planning unit that a bed is not reserved for the recipient. The procedure detailed in Section 456.515(A)(5) should then be followed.

(C) If the recipient is transferred to another hospital (e.g., chronic, psychiatric, acute) during the ten-day period, the PSRO Utilization Review coordinator shall:

(1) notify the long term care facility by telephone of the recipient's transfer. If the recipient is transferred to a non-acute care hospital, the bed reservation must be terminated on the date of notification. The procedures outlined in Section 456.515(A)(5) must be followed;

(2) in cases of transfer to an acute care hospital on or before the fifth day of the recipient's absence from the long term care facility, send the Bed Reservation Form to the new hospital as soon as possible. In cases of transfer to an acute care hospital after the fifth day of the recipient's absence from the long term care facility, the facility must be notified by telephone and the bed reservation terminated on the date of notification. The appropriate notations should be made on the Bed Reservation Form; and

(3) in all other transfer cases, follow the procedure detailed in Section 456.515(A)(5).

(D) If the recipient dies in the hospital, or is transferred to another long term care facility within the ten-day period, the PSRO Utilization Review coordinator shall:

(1) notify the original long term care facility by telephone that the bed reservation for the recipient must terminate effective on the date of notification; and

(2) make the appropriate notations on the Bed Reservation Form and distribute copies according to the procedures outlined in Section 456.515 (A)(5).

456.516 Billing and Reimbursement

(A) Reimbursement for a bed reservation shall be terminated upon the date of telephone notification from the PSRO Utilization Review coordinator (in the case of a termination) or after the tenth full day of the recipient's absence from the long term care facility. Under no circumstances will the Department reimburse the facility for reserving the recipient's bed beyond the ten-day period.

(B) A bed being reserved and paid for under these regulations shall not be temporarily occupied by another resident at the facility.

(C) In the case of a bed reservation authorized after a new estimated length of stay, the facility shall not bill retroactively to an earlier date in the recipient's hospital stay, but shall bill from the date of the telephone notification of the new length of stay estimate through the tenth full day of the recipient's absence from the facility.

(D) Reimbursement for a bed reservation shall be terminated upon the date of notification from the PSRO Utilization Review coordinator when a recipient is transferred from an acute care hospital to either a chronic care or psychiatric hospital within the ten-day period.

(E) Every patient day properly claimed by a facility according to these regulations shall count as a day during which the bed is occupied for the purposes of the Massachusetts Rate Setting Commission formula.

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FREE-STANDING SPEECH AND HEARING CENTERS

461.150: Introduction to Fee Schedule

(A) General Requirements.

(1) The rate of payment shall be the lowest of either the provider's usual fee to patients other than Medical Assistance recipients, the provider's actual charge, or the fee schedule amount listed here.

(2) A procedure or test that is designated "I.P." means an independent procedure that can only be billed when done alone. Ordinarily such tests are included as part of a battery of tests or are part of a complete evaluation.

(3) Rates of payment for authorized services not listed herein shall be determined on an individual consideration (I.C.) basis. A report must be submitted with the claim form describing the services furnished. Determination of appropriate payment for authorized I.C. services shall be in accordance with the following criteria:

(a) a complete description of the service and the results;
(b) the time spent performing the service;
(c) the degree of skill required for the service;
(d) the severity and complexity of the recipient's disorder or disability;
(e) the policies, procedures, and practices of other third-party purchasers of care, governmental and private;
(f) prevailing audiology ethics; and
(g) such other standards and criteria as may be adopted by other governmental purchasing agencies.

(B) Definitions.

(1) Audiological Services -- testing related to the determination of hearing loss, evaluation with hearing aids, prescription of hearing aid devices, and aural rehabilitation, which includes lip reading and auditory training.

(2) Aural Rehabilitation -- therapy provided by a qualified audiologist either in a group or individually.

(a) Lip reading is the training of the visual modality to improve the understanding of the speech or language of other speakers.
(b) Auditory training is the training of the auditory modality to improve the understanding of the speech or language of other speakers.

(3) Complete Audiological Evaluation -- an evaluation that includes a routine audiological evaluation plus site-of-lesion testing (impedance testing and/or recruitment testing) as needed or recommended by a physician.

(4) Hearing Aid Evaluation -- a procedure that includes:
(a) an assessment of the recipient's performance by appropriate tests with hearing aid devices;
(b) if a hearing aid is prescribed: a recheck of the recipient and hearing aid after the prescribed aid has been fitted and used for a trial period; and
(c) if a hearing aid is prescribed: counseling related to the recipient's adjustment to the use of the hearing aid.

(5) Infant Testing -- these procedures may include behavioral audiometry, conditioned orientation reflex audiometry (COR), visual reinforcement audiometry (VRA), and/or tangible reinforcement operant conditioning audiometry (TROCA), plus impedance testing. The complete procedure includes an initial interview with detailed history, the testing, an explanation of results and parent counseling, a written report, and consultation with other disciplines. The evaluation requires an audiologist certified by the American Speech and Hearing Association plus another qualified staff professional who are skilled in working as a team during the infant assessment and observation. The audiologist must be skilled in performing the infant assessment procedures. Specialized equipment is required.

(6) Nonorganic Test Battery -- tests to determine functional hearing loss.

(7) Routine Audiological Evaluation -- a procedure that includes:
(a) pure-tone audiogram, by air and bone conduction testing; and
(b) speech reception and discrimination testing.

(8) Speech/Language Pathology Services -- the evaluation and treatment of communication disorders with regard to the functions of articulation (including apraxia and dysarthria), language, voice, and fluency.

461.151: Fee Schedule

Service Code	Service Description	Allowable Fee
035001	Routine audiological evaluation: includes pure-tone audiogram (air and bone conduction) and speech reception and discrimination testing (I.P.)	$ 17.90
035002	Complete audiological evaluation: includes routine audiological evaluation and site-of-lesion testing (impedance and/or recruitment testing) (I.P.)	29.50
	Hearing aid evaluation	
035003	Initial visit (I.P.)	16.35
035004	Follow-up visit (I.P.)	11.30

Service Code	Service Description	Allowable Fee
	Routine audiological evaluation and hearing aid evaluation	
035008	Initial visit	$ 27.30
035009	Follow-up visit	11.95
035007	Complete audiological evaluation with check of recipient's personal hearing aid (includes hearing aid evaluation with the aid and electro-acoustical analysis of the aid)	28.25
	Aural rehabilitation: lip reading or auditory training	
035010	Individual	18.85/hour
035011	Group therapy (up to 60 minutes), each recipient	9.45/hour
	Speech and language therapy	
035015	Brief office visit (up to 25 minutes)	9.00
035016	Routine office visit (treatment in excess of scope of brief office visit, up to 60 minutes)	18.00
035017	Comprehensive speech and/or language evaluation	44.00
035018	Group therapy (up to 60 minutes), 2 to 6 persons, each recipient	9.00
	Home visit for audiological and hearing aid evaluation (includes all expenses related to travel)	
035024	Initial visit: first recipient	29.55
035025	Initial visit: each additional recipient	23.55
035026	Follow-up visit: first recipient	18.55
035027	Follow-up visit: each additional recipient	12.55
	Home visit for audiological evaluation only (includes all expenses related to travel)	
035028	First recipient	24.85
035029	Each additional recipient	18.85

Service Code	Service Description	Allowable Fee
	Special test battery	
035031	Nonorganic test battery	$ 9.40
035032	Infant testing (I.P.)	35.00
	Single test	
035033	Pure-tone audiogram (air and bone conduction) (I.P.)	9.75
035034	Impedance testing (includes tympanogram and acoustic reflex) (I.P.)	5.00
	Unlisted service	
035036	Single test (rather than a battery or complete evaluation)	I.C.
035037	Other unlisted service	I.C.

FREE-STANDING REHABILITATION CENTERS

461.450 Introduction to Fee Schedule

(A) The rate of payment shall be the lower of either the provider's usual fee to patients other than Medical Assistance recipients, the provider's actual charge, or the fee schedule amount listed here.

(B) The rates of payment in this fee schedule do not apply to the following services:

(1) medical services except as are required for a comprehensive rehabilitation evaluation;

(2) psychology services; and

(3) audiology services.

461.451 Definitions for Fee Schedule

For clarity in interpreting the fee schedule, the following phrases are defined:

(A) Rehabilitation -- the process of providing, in a coordinated manner, those comprehensive services deemed appropriate to the needs of a physically disabled or handicapped individual, in a program designed to achieve objectives of improved health and welfare with realization of his maximum physical, social, psychological, and vocational potential for useful and productive activity.

(B) Comprehensive Rehabilitation Evaluation -- a neuro-muscular orthopedic functional assessment performed at the clinic by a physician.

(C) Rehabilitation Treatment -- a patient visit involving services of one or more disciplines provided by therapists or medical practitioners.

(D) Half-Hour Treatment -- a patient visit for a rehabilitation treatment of thirty (30) minutes.

(E) One-Hour Treatment -- a patient visit for a rehabilitation treatment in excess of a half-hour treatment up to sixty (60) minutes.

(F) One-and-a-Half-Hour Treatment -- a patient visit for a rehabilitation treatment in excess of a one-hour treatment up to an hour and a half (90 minutes).

(G) Two-and-a-Half-Hour Treatment -- a patient visit for a rehabilitation treatment in excess of a one-and-a-half-hour treatment up to two and a half hours.

(H) Greater Than Two-and-a-Half-Hour Treatment -- a patient visit for a rehabilitation treatment of more than two and a half hours.

(I) Group Session -- therapeutic services directed toward more than one patient in a single visit, utilizing group participation and interaction as a treatment technique.

(J) Individual Consideration -- the rate of payment for procedures performed in exceptional circumstances are determined on an individual consideration (I.C.) basis upon receipt of a bill which describes the services rendered. Determination of appropriate payment for authorized I.C. procedures shall be in accordance with the following criteria: the time required to perform the procedure, degree of skill required, severity and complexity of the patient's disorder or disability, and prevailing rehabilitation ethics and accepted customs.

461.452 Fee Schedule

Service Code	Procedure Description	Allowable Fee
136001	Comprehensive Rehabilitation Evaluation (written report required)	$25.00
136002	Re-evaluation (written report required)	15.00
136003	Half-hour treatment	8.00
136004	One-hour treatment	12.00
136005	One-and-a-half-hour treatment	16.00
136006	Two-and-a-half-hour treatment	24.00
136007	Greater than two-and-a-half-hour treatment	28.00
136008	Group session	I.C.*

*Individual consideration

MEDICAL ASSISTANCE PROGRAM
LABORATORY SERVICES

Chapter 472.000

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472.001 Recipient Eligibility

Laboratory services are available for both Medical Assistance recipients (categories 00, 01, 02, 03, 05, 06, 07, and 08) and General Relief Medical Assistance recipients (category 04). Services provided to a General Relief Medical Assistance recipient in or by a hospital laboratory, specialty clinic, or family planning agency, however, are not payable by the Department.

472.002 Prescriber's Written Request for Laboratory Services

A provider of laboratory services must obtain a written request for services signed by the prescriber (licensed physician, dentist, or podiatrist).

472.003 Service Locations

Laboratory services may be performed in the following locations if the provider is participating in the Medical Assistance Program:

(A) independent laboratories;

(B) hospital laboratories;

(C) physicians' offices;

(D) neighborhood health centers;

(E) family planning agencies; and

(F) ambulatory gynecological clinics.

472.004 Regulations for Independent Laboratories

The Department's regulations governing the participation of independent laboratories have been promulgated as: Independent Laboratory Manual (106 CMR 401.000).

MEDICAL ASSISTANCE PROGRAM
TRANSPORTATION SERVICES

Chapter 476.000

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476.001 Introduction

Federal regulations of 42 CFR 449.10(a)(5)(ii) require that each state's Medicaid plan must make provision for ensuring necessary transportation of recipients to and from providers of services. In meeting that obligation, the Department has elected, pursuant to 42 CFR 449.10(b)(17)(i) to include transportation as an item of medical assistance subject to the conditions and limitations set forth in these regulations.

476.002 Definitions

The following definitions apply when used in these regulations:

(A) Ambulance -- a motor vehicle that is equipped to transport sick, injured, or wounded persons, is operated by a licensed service, and has a valid Certificate of Inspection of Ambulance as a Class I, II, IV, or V ambulance issued by the Massachusetts Department of Public Health under M.G.L. c. 111C. All ambulance providers must participate in the Medicare (Title XVIII) program in order to be eligible to participate in the Medical Assistance Program.

(B) Chair Car -- a motor vehicle that is specifically equipped to carry one or more persons who are mobility handicapped or confined to a wheelchair, and is certified as a Class III ambulance by the Massachusetts Department of Public Health under M.G.L. c. 111C.

(C) Dial-a-Ride -- a motor vehicle for hire that is used to transport persons on a demand-response, shared-ride basis, and is licensed by the city or town where the business is located. Any dial-a-ride service that also operates as a chair car (Class III ambulance) must be additionally licensed by the Massachusetts Department of Public Health.

(D) Loaded Miles -- that distance traveled while a recipient is in the vehicle.

(E) Other Licensed Carrier -- any licensed carrier, including bus, train, plane, or boat, that is licensed by the appropriate licensing board or agency.

(F) Private Transportation -- transportation by a carrier of persons operated by an entity other than a state or a political subdivision thereof.

(G) Public Transportation -- transportation by a carrier of persons operated by a city, town, county, authority, or other political subdivision of a state.

(H) Taxi -- a motor vehicle for hire that is used to transport persons on an individual basis and is licensed by the city or town where the business is located.

(I) Waiting Time -- the time spent by a vehicle and its driver and attendants in waiting to return a recipient to the point of trip origin. Waiting time applies only when the recipient is not in the vehicle.

476.003 Recipient Eligibility

Transportation services are reimbursable for all Medical Assistance recipients except General Relief recipients (category 04).

476.004 Project Good Health

The Department must offer and, when appropriate under policy provisions, provide transportation services to all Medical Assistance recipients under 21 years of age to facilitate their access to comprehensive health care.

476.005 Provider Eligibility: In-State

(A) To be eligible for reimbursement under the Medical Assistance Program, a potential provider must complete a provider application form and must be assigned a specific provider number by the Department.

(B) The Department will accept and approve provider applications from providers who qualify and meet given regulations or conditions of participation as are adopted by the Massachusetts Department of Public Health or the Department of Public Welfare for one or more of the following modes of transportation: dial-a-ride, taxi, chair car, ambulance, or other licensed carrier. Hospitals participating in the hospital/taxi program and adult day health programs are considered eligible providers for purposes of these regulations.

476.006 Provider Eligibility: Out-of-State

Transportation services furnished by an out-of-state provider may be reimbursed under the Medical Assistance Program only if the provider submits an application to become an approved provider in the Massachusetts Medical Assistance Program and is assigned a specific provider number by the Department. An out-of-state provider must have a valid license issued by the appropriate regulatory agency within its state to be approved as a provider in the Massachusetts Medical Assistance Program.

476.010 Transportation Utilization Restrictions: Reimbursable Services

Transportation services are reimbursable only when recipients are traveling to obtain medical services that are reimbursable under the Medical Assistance Program.

(A) It is the responsibility of the recipient's Welfare Service Office to determine which medical services are reimbursable under the Medical Assistance Program in the case of taxi, dial-a-ride, bus, and public transportation.

(B) It is the responsibility of the transportation provider to judge which medical services are reimbursable in the case of ambulance and chair-car transportation and to advise the recipient in cases where transportation is requested to a service that, in the provider's judgment, may not be or is not reimbursable. If a recipient should be in doubt as to whether or not a service is reimbursable, he should contact his local Welfare Service Office or Community Service Area Office.

476.011 Transportation Utilization Restrictions: Non-Reimbursable Services

The following are examples of transportation services that are not reimbursable:

(A) transportation to child day-care centers and nurseries;

(B) transportation of persons who are elderly or disabled to adult day health programs, except when arranged by special contract with the Medical Assistance Adult Day Health Program;

(C) transportation to schools, summer camps, and recreational programs (e.g., swimming classes);

(D) transportation of family members to visit a hospitalized or institutionalized recipient;

(E) transportation to a medical facility or physician's office for the sole purpose of obtaining a medical recommendation for homemaker/chore services. Such medical recommendation can be obtained from a social worker in accordance with the Massachusetts Social Services Policy Manual, Chapter II, pages II-3-1 through II-3-3, item VI.A, or Chapter III, pages III-13-14 through III-13-16, item VI.A;

(F) transportation to governmental agency offices;

(G) transportation to visit a child in foster-care placement or in group-care placement;

(H) transportation to pharmacies to obtain medications; and

(I) transportation to obtain Computerized Axial Tomography (CAT) scans at a facility other than one of the following:

Bay State Medical Center, Springfield
Boston City Hospital, Boston
Carney Hospital, Dorchester
Lahey Clinic, Boston
Union Hospital, Lynn
Massachusetts General Hospital, Boston
Medical Center of Worcester, Worcester
Peter Bent Brigham Hospital, Boston
St. John's Hospital, Lowell
St. Vincent's Hospital, Worcester
Sidney Farber Cancer Institute, Inc., Boston
(Charles A. Dana Hospital)
Tufts New England Medical Center, Boston

476.012 Transportation Utilization Restrictions: Locality Restrictions

In general, the Department will pay for a recipient to be transported to sources of medical care only within the recipient's locality. Locality refers to the town or city in which the recipient resides and immediately adjacent communities. However, when necessary medical services are unavailable in the recipient's locality, medical transportation to the nearest medical facility in which treatment is available is reimbursable.

476.013 Transportation Utilization Restrictions: Institutionalized Recipients

When specialized equipment required for medical treatment is not available at a facility, the infirm recipient may be transported to the site of the equipment. Medical services that may require specialized equipment include X-ray services, cast removal, fitting for artificial limbs, and radiation therapy.

476.014 Transportation Utilization Restrictions: Types of Transportation

Recipients must utilize personal transportation resources such as family or friends whenever possible. When personal transportation resources are unavailable, a recipient must utilize public transportation, if available in his locality and suitable to his medical condition. Private transportation is reimbursable only when public transportation suitable to the recipient's medical condition is unavailable.

476.015 Transportation Utilization Restrictions: Shared Ride

When two or more recipients are traveling to the same destination at the same time, they must share transportation when such arrangements are made by the Department, the transportation provider, or the medical provider.

476.020 Authorization for Transportation: Types of Authorization

All forms of transportation except rapid transit and local buses require authorization. The authorization must consist of the following:

(A) prior authorization from the Department;

(B) a prescription written by a physician or dentist;

(C) a completed Medical Necessity Form; or

(D) a combination of the above.

Specific authorization requirements for each mode of transportation are delineated in the sections of regulations for each type of vehicle.

476.021 Authorization for Transportation: Prior Authorization from or Consultation with Regional Medical Unit or Medical Division (Central Office)

When prior authorization or consultation is required from the Medical Division (also referred to as the Central Office) or the Regional Medical Unit, prior authorization or consultation must be obtained from the proper office designated below:

(A) for Boston only: Boston Regional Office (617) 227-8320, extension 376 or 377;

(B) for Berkshire, Franklin, Hamden, and Hampshire counties: Springfield Regional Office (413) 781-7510; and

(C) for all other areas: Medical Division in Boston (617) 727-8080.

476.022 Authorization for Transportation: Prescription Written by a Physician or Dentist

(A) A prescription for dial-a-ride or taxi transportation must be written by a physician or dentist on:

(1) the letterhead of the physician or dentist or the medical facility with which he is affiliated; or

(2) a Medical Assistance Program transportation prescription form.

(B) A written prescription must contain the following information:

(1) the recipient's identification, including his name, address, and 10-digit Medicaid cardholder number;

(2) the specific physical or mental disability that prohibits the use of rapid transit or bus;

(3) the medical care that will be received;

(4) how often transportation is needed (specific dates or specified number of trips per week for specific month);

(5) destination of the trip (the name and address of a specific institution or the physician's or dentist's name and office address);

(6) the expected duration of the need for transportation (specific time period not to exceed three months for acute illness and one year for chronic illness),

(7) the date on which the prescription is written;

(8) the signature of the physician or dentist;

(9) if the recipient is residing in a skilled nursing or intermediate care facility, the necessary medical services or equipment that are needed and can not be obtained in the facility; and

(10) if the treatment destination is outside the recipient's locality, the necessary medical services or equipment that are needed and can not be obtained locally.

476.023 Authorization for Transportation: Medical Necessity Form

(A) Purpose

The Medicare/Medicaid Medical Necessity Form is used to document medical necessity for non-emergency ambulance and chair-car trips. Only a physician or a physician's designee may complete a Medical Necessity Form.

(B) Physician's Responsibility

The physician who requests an ambulance or chair car for a recipient, or the physician's designee, must complete a Medical Necessity Form at the time of transfer of the recipient, giving the specific physical disability that necessitates the mode of transportation requested. The physician's name must be entered on the form where indicated if he is not the person completing the form. Information given on the Medical Necessity Form must be supported by the recipient's medical record.

(C) Transportation Provider's Responsibility

(1) The transportation provider must give a blank Medical Necessity Form to the physician or his designee for completion at the time of transfer of the recipient. This may be done at the trip's origin or destination.

(2) Transportation providers are responsible for completeness of Medical Necessity Forms. The Department will deny claims accompanied by incomplete or unsigned Medical Necessity Forms.

(D) Recurring Need

When a recipient must travel eight or more times per month to the same destination for a period of two months or more, a physician may authorize all trips for one month (any 30-day period) on one Medical Necessity Form. The dates of each trip and the total number of trips must be entered on the form.

476.030 Reimbursement to Recipients for Transportation Expenses

(A) Reimbursable Expenses

Recipients may obtain direct reimbursement from the Department for expenses incurred in traveling to reimbursable medical care. Reimbursement for transportation is limited to the following expenses:

(1) private automobile costs when the use of a private automobile was less expensive than other available transportation;

(2) public transportation costs (MBTA, local buses);

(3) any licensed carrier costs, when there is no transportation provider in recipient's locality and when documentation of medical necessity for the mode of transportation used can be provided by a physician; and

(4) dial-a-ride or taxi transportation costs in cases of urgent medical need when the recipient's Welfare Service Office is closed.

(B) Method and Amount of Reimbursement

(1) In order to obtain reimbursement for transportation expenses, a recipient must obtain documentation from his physician, registered nurse, licensed practical nurse, or medical facility social worker that reimbursable medical services were received. The documentation must give the date on which medical services were received as well as the specific address where medical services were received. In cases of urgent medical need, the documentation must also state the time medical services were received to verify that the Welfare Service Office or Community Service Area Office was closed. Transportation receipts are also required when available. The recipient must submit documentation and receipts to his local Welfare Service Office and request reimbursement for transportation expenses.

(2) Transportation costs must total $10.00 or more for the recipient to request reimbursement. The recipient must submit a request for reimbursement no later than 90 days after the earliest date on which transportation costs in excess of $10.00 occurred. The amount of reimbursement for automobile costs shall be the lesser of the automobile mileage cost as calculated from the Department's mileage manual utilizing the reimbursement rate currently authorized for Department employees, and the cost of other available transportation.

(3) If a recipient traveled outside his locality, as defined in Section 476.012, the documentation must state what necessary medical services were needed that could not be obtained locally. If a recipient traveled outside his locality when necessary medical services were available locally, transportation costs incurred are not reimbursable.

476.031 Reimbursement to Providers for Transportation Services

(A) Amount of Reimbursement

Payment for transportation is made directly to providers of services except in the circumstances specified in Section 476.030. The maximum allowable fee for transportation services provided to recipients shall be the fee established for the service by the Massachusetts Rate Setting Commission or the provider's usual and customary charge, whichever is lower. When a recipient and an individual who is not a recipient are transported together, the recipient shall be considered the "additional person" for billing purposes as specified in Sections 476.065 and 476.076.

(B) Usual and Customary Charge Definition

The term "usual and customary charge" means the amount a provider would charge, for substantially the same service, to an individual who is not eligible for direct public assistance for that service. However, a special rule may apply to certain providers who operate low-cost transportation systems intended to benefit classes of individuals for whom no direct public assistance, insurance coverage, or other sources of third-party payment are available, where the amount charged to such individuals is less than the actual cost of providing the service, and the operation of the system depends upon higher charges for services to individuals who have third-party sources of payment. In such cases, if the provider can demonstrate, by evidence satisfactory to the Department, that its charges for services to individuals who are not eligible for direct public assistance are significantly less than the cost of providing the services, the Department will establish a rate under individual consideration, which will be deemed the provider's usual and customary charge for the purpose of reimbursement by the Department. In no event shall this established rate exceed either the maximum fee established by the Massachusetts Rate Setting Commission or the actual cost of the service.

476.040 Dial-a-Ride: Type of Service

Dial-a-ride is a motor vehicle for hire designed to transport persons on a demand-response, ambulatory, shared-ride basis.

476.041 Dial-a-Ride: Criteria for Use

Dial-a-ride services are for persons whose physical or mental disabilities render them unable to use rapid transit or bus service, or who have no rapid transit or bus service available to them. The following criteria apply to use of dial-a-ride transportation:

(A) Physicial inability to use rapid transit or bus means that a person needs assistance to walk or is unable to climb bus steps.

(B) Mental inability to use rapid transit or bus means that a person has crowd phobias, dementia, or violent or assaultive behavior, or is seriously confused and disoriented.

(C) Lack of escort for a young child is not an appropriate criterion for the use of dial-a-ride transportation.

(D) When no public transportation is available and all other resources such as family, friends, and community service groups have been exhausted, the Department will approve dial-a-ride transportation only to the nearest public transportation, unless dial-a-ride transportation for the entire distance is less costly than dial-a-ride combined with public transportation.

476.042 Dial-a-Ride: Prescription Requirement

All dial-a-ride transportation requires a physician's or dentist's prescription detailing the recipient's physical condition that prohibits the use of rapid transit or bus service, with the following exceptions:

(A) The first medical or dental appointment for Project Good Health recipients does not require a prescription. However, careful documentation of medical necessity must be entered in the recipient's record by the social worker.

(B) When no public transportation is available and all other resources (family, friends, and community service groups) have been exhausted, a prescription is not required. Availability of public transportation means that a public system is operated in the area on a regularly scheduled basis. A wait of up to one hour for a regularly scheduled public transport, or up to two transfers in transit, is not unreasonable. Careful documentation of lack of other transportation must be entered in the recipient's record by the social worker.

(C) When urgent medical need requires immediate dial-a-ride transportation to a physician's or dentist's office or to a hospital and there is no prescription on file with the recipient's Welfare Service Office or Community Service Area Office, prior authorization may be issued by the Department without a prescription with the provision that the recipient obtain a prescription from his physician or dentist verifying the urgent medical need for dial-a-ride transportation. Such a prescription must be submitted to the Welfare Service Office or Community Service Area Office within two business days after the day on which prior authorization was issued. Failure to submit the required prescription will result in denial of subsequent urgent medical-need requests within a three-month period.

476.043 Dial-a-Ride: Authorization Requirement

All dial-a-ride transportation requires prior authorization from the recipient's local Welfare Service Office or Community Service Area Office. The Department will issue a prior authorization only when the request is accompanied by a completed physician's or dentist's prescription, if required. Prior authorization is for health-care necessity only. Payment is still subject to all general conditions of the Department, including current recipient eligibility, third-party resources, and program restrictions.

476.044 Dial-a-Ride: Consultation with Regional Medical Unit or Medical Division (Central Office)

In the following situations, persons designated by the Welfare Service Offices and Community Service Area Offices to be Medical Assistance transportation persons must consult with the Regional Medical Unit or the Medical Division (Central Office) as set forth in Section 476.021 before issuing prior authorization for dial-a-ride transportation:

(A) when the recipient is traveling outside his locality to obtain medical care;

(B) when there is recurring need (eight or more trips per month to the same destination for a period of two months or more); and

(C) when the medical necessity is questionable.

476.045 Dial-a-Ride: Recordkeeping Requirement

(A) Providers of dial-a-ride services must retain records of all services billed to the Department.

(B) Such records shall be maintained for a period of at least four years and must include a log or trip sheet separate from the claim form containing the name of the recipient transported, the date of service, and the origin and destination of the trip.

476.046 Dial-a-Ride: Rates of Payment

Rates of payment for dial-a-ride services shall be established by the Department under individual consideration at the time of application to become a provider by the dial-a-ride service. Rates shall be based on actual cost data.

476.047 Dial-a-Ride: Procedure Codes

(A) For one-way dial-a-ride services, a specific code will be assigned to each provider.

(B) For round-trip dial-a-ride services, a specific code will be assigned to each provider.

476.050 Taxi: Type of Service

A taxi is a motor vehicle for hire that transports people on an individual basis.

476.051 Taxi: Criteria for Use

Taxi services are for persons whose physical or mental disabilities render them unable to use rapid transit or bus service, or for whom no dial-a-ride service, rapid transit, or bus service is available.

(A) Physical inability to use rapid transit or bus means that a person needs assistance to walk or is unable to climb bus steps.

(B) Mental inability to use rapid transit or bus means that a person has crowd phobias, dementia, or violent or assaultive behavior, or is seriously confused and disoriented.

(C) Lack of an escort for a young child is not an appropriate criterion for use of a taxi.

(D) When no public transportation is available and all other resources such as local agency dial-a-ride, family, friends, and community service groups have been exhausted, the Department will approve taxi transportation only to the nearest public transportation, unless taxi transportation for the entire distance is less costly than taxi combined with public transportation.

476.052 Taxi: Prescription Requirement

All taxi transportation requires a physician's or dentist's prescription detailing the recipient's physical condition that prohibits the use of rapid transit or bus service, with the following exceptions:

(A) The first medical or dental appointment for Project Good Health recipients does not require a prescription. However, careful documentation of medical necessity must be entered in the recipient's record by the social worker.

(B) When no public transportation is available and all other resources (family, friends, community service groups, and local agency dial-a-ride) have been exhausted, a prescription is not required. Availability of public transportation means that a public system is operated in the area on a regularly scheduled basis. A wait of up to one hour for a regularly scheduled public transport, or up to two transfers in transit, is not unreasonable. Careful documentation of lack of other transportation must be entered in the recipient's record by the social worker.

(C) When urgent medical need requires immediate taxi transportation to a physician's or dentist's office or to a hospital and there is no prescription on file with the recipient's Welfare Service Office or Community Service Area Office, prior authorization may be issued by the Department without a prescription with the provision that the recipient obtain a prescription from his physician or dentist verifying the urgent medical need for taxi transportation. Such a prescription must be submitted to the Welfare Service Office or Community Service Area Office within two business days after the day on which prior authorization was issued. Failure to submit the required prescription will result in denial of subsequent urgent medical-need requests within a three-month period.

476.053 Taxi: Authorization Requirement

All taxi transportation requires prior authorization from the recipient's local Welfare Service Office or Community Service Area Office. The Department will issue a prior authorization only when the request is accompanied by a completed physician's or dentist's prescription, if required. Prior authorization is for health-care necessity only. Payment is still subject to all general conditions of the Department, including current recipient eligibility, third-party resources, and program restrictions.

476.054 Taxi: Consultation with Regional Medical Unit or Medical Division (Central Office)

In the following situations, persons designated by the Welfare Service Offices and Community Service Area Offices to be Medical Assistance transportation persons must consult with the Regional Medical Unit or the Medical Division (Central Office) as set forth in Section 476.021 before issuing prior authorization for taxi transportation:

(A) when the recipient is traveling outside his locality to obtain medical care;

(B) when there is recurring need (eight or more trips per month to the same destination for a period of two months or more); and

(C) when the medical necessity is questionable.

476.055 Taxi: Recordkeeping Requirement

(A) Providers of taxi services must retain records of all services billed to the Department.

(B) Such records shall be maintained for a period of at least four years and must include a log or trip sheet separate from the claim form containing the name of the recipient transported, the date of service, and the origin and destination of the trip. If two or more persons were transported together, the provider must record this on the log or trip sheet.

476.056 Taxi: Rates of Payment

(A) Payment for taxi transportation shall be the provider's usual and customary charge not to exceed the established legal rate as recorded on the taxi meter. Taxi companies which do not use a meter system must charge according to the exact fee schedule submitted by them to and approved by the Department. Taxi charges may be applied only for loaded miles.

(B) The Department reimburses for waiting time at $5.00 per hour only when taxi transportation exceeds 40 miles round trip. Payment shall not be made for more than two hours of waiting time. The charge is to be calculated to the nearest quarter hour.

(C) For two or more passengers carried on the same trip, the usual and customary charge shall not exceed the established legal rate as recorded on the taxi meter or that fee schedule approved by the Department from the point of the first pickup to the destination. The total fare will be split equally among the passengers carried, unless one passenger is required as an assistant for the recipient. In such cases, the recipient and his assistant shall be considered one passenger for billing purposes.

476.057 Taxi: Procedure Codes

(A) For an individual passenger, use Procedure Code 168620.

(B) For waiting time, use Procedure Code 168621.

(C) For two or more passengers, use Procedure Code 168622.

476.060 Chair Car: Type of Service

A chair car is a motor vehicle specifically equipped to carry persons who are mobility handicapped or confined to wheelchairs.

476.061 Chair Car: Criteria for Use

Chair car services may be provided only in non-emergency situations to the following persons:

(A) those who are confined to wheelchairs;

(B) those who need to be carried up or down stairs (because they are unable to ambulate stairs or can not walk without the assistance of two persons); and

(C) those whose severe mobility handicaps prevent them from using public, dial-a-ride, or taxi transportation.

476.062 Chair Car: Medical Necessity Form Requirement

Chair-car transportation requires a Medicare/Medicaid Medical Necessity Form completed by the attending physician or his designee.

476.063 Chair Car: Authorization Requirement

A Medicare/Medicaid Medical Necessity Form serves as authorization for chair-car transportation except in the following cases, which require prior authorization from the Medical Division (Central Office) or Regional Medical Unit:

(A) the second and succeeding round trips provided to a recipient in one day;

(B) transportation to a medical provider outside a recipient's locality;

(C) all out-of-state transportation except when the destination is a town or city within a recipient's locality;

(D) trips from one skilled nursing or intermediate care facility to another when no change in level of care is involved; and

(E) transportation between like hospitals (chronic to chronic, acute to acute) except when lack of necessary medical services or knowledge of the recipient's medical history at one hospital requires transfer to another.

476.064 Chair Car: Recordkeeping Requirement

(A) Providers of chair-car services must retain records of all services billed to the Department.

(B) Such records shall be maintained for a period of at least four years and must include a log or trip sheet separate from the claim form containing the name of the recipient transported, the date of service, the origin and destination of the trip, the vehicle identification number, and whether or not a second attendant is required. If two or more persons are transported together, the provider must record this on the log or trip sheet.

476.065 Chair Car: Rates of Payment

Rates of payment for chair-car (Class III ambulance) services as set by the Massachusetts Rate Setting Commission are as follows:

(A)	Base Fee -- one way	$14.00
	Each additional person	7.00
(B)	Base Fee -- round trip	28.00
	Each additional person	14.00
(C)	Second attendant (per one-way trip)	5.00
(D)	Mileage fee per loaded mile after five miles one way, ten miles round trip	.50

(E) When more than one recipient is transported in the same vehicle, the mileage fee after five miles shall apply only once.

476.066 Chair Car: Procedure Codes

(A) For one-way services, use Procedure Code 168701.

(B) For round-trip services, use Procedure Code 168702.

(C) For an additional person, use Procedure Code 168703.

(D) For a second attendant, use Procedure Code 168704.

476.070 Ambulance: Type of Service

An ambulance is a highly specialized vehicle equipped to transport sick, injured, or wounded persons whose health would be endangered if any other method were used.

476.071 Ambulance: Criteria for Use

(A) Emergency Situations

Ambulance services are always reimbursable in emergency situations. An emergency situation is defined as one in which the recipient has a critical or unknown illness or injury that apparently demands immediate medical attention at a hospital to prevent permanent injury or loss of life. Emergency cases must be transported to the nearest medical facility equipped for and capable of treating such emergency cases.

(B) Non-Emergency Situations

In non-emergency situations, ambulance services are reimbursable when medically necessary as set forth in Section 476.072. The return trip of an emergency transport is considered a non-emergency situation.

476.072 Ambulance: Conditions Always Requiring Transportation by Ambulance

(A) Medical Conditions

The following medical conditions always require transportation by ambulance:

(1) continually dependent on oxygen;

(2) continually confined to bed;

(3) American Heart Association Class IV patients with diseases of the heart; recipients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased;

(4) receiving intravenous treatment;

(5) after cardiac catheterization; or

(6) having uncontrolled seizure disorders.

(B) Orthopedic Conditions

The following orthopedic conditions always require transportation by ambulance:

(1) total body cast; or

(2) hip spicas and other casts which prevent flection at the hip.

(C) Pediatric

If the recipient is in an isolette (incubator), ambulance transportation is required.

(D) Psychiatric

The following psychiatric conditions always require transportation by ambulance:

(1) needing restraints (possibly harmful to self or others, including persons transported under M.G.L. c. 123 s. 12 for temporary hospitalization by reason of mental illness). Defined in M.G.L. c. 123 s. 1, "likelihood of serious harm" provision: "(1) substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community."; or

(2) heavily sedated.

(E) Neuro-Surgical

The following neuro-surgical conditions always require transportation by ambulance:

(1) continually confined to bed (severe brain damage, for example);

(2) comatose; or

(3) after pneumo-encephalogram.

476.073 Ambulance: Medical Necessity Form Requirement

(A) Emergency ambulance trips do not require a prescription. However, the nature of the emergency must be supported by medical records at the hospital to which the recipient was transported.

(B) Non-emergency ambulance transportation requires a Medicare/Medicaid Medical Necessity Form completed by the attending physician or his designee.

476.074 Ambulance: Authorization Requirement

A Medicare/Medicaid Medical Necessity Form serves as authorization for non-emergency ambulance transportation except in the following cases, which require prior authorization from the Medical Division (Central Office) or Regional Medical Unit:

(A) the second and succeeding round trips provided to a recipient in one day;

(B) transportation to a medical provider outside a recipient's locality;

(C) transportation by ambulance to a physician's office;

(D) all out-of-state transportation except when the destination is a town or city within a recipient's locality;

(E) trips from one skilled nursing or intermediate care facility to another when no change in level of care is involved; and

(F) transportation between like hospitals (chronic to chronic, acute to acute) except when lack of necessary medical services or knowledge of the recipient's medical history at one hospital requires transfer to another.

476.075 Ambulance: Recordkeeping Requirement

(A) Providers of ambulance services must retain records of all services billed to the Department.

(B) Such records shall be maintained for a period of at least four years and must include a log or trip sheet separate from the claim form containing the vehicle number, time of the trip, the driver's name, the name of the recipient transported, the date of service, the origin and destination of the trip, and the nature of the ambulance service furnished. For emergency trips, the nature of the emergency must be recorded in detail, including referring source.

476.076 Ambulance: Rates of Payment

(A) Rates of payment for Class I, Class II, and Class II Temporary Ambulance Services as set by the Massachusetts Rate Setting Commission are as follows:

(1) Base fee per trip	$41.00
(2) Mileage fee per trip, per loaded mile after 20 miles only	.50

(B) An ambulance trip may be considered a round trip if the waiting time exceeds one hour. Reimbursement for such trips is double the base fee, plus mileage per loaded mile after 20 miles each way.

(C) When two persons are transported in the same vehicle, reimbursement for the additional person shall be one-half the base fee. In such instances, the mileage fee shall apply only once.

(D) This fee schedule does not authorize additional or supplemental payment for oxygen service, for a nurse or extra attendant, or for waiting time.

(E) The Department shall consider the amount payable for an authorized Class IV, Class V, or Class V Temporary Ambulance Service trip on an individual consideration basis.

476.077 Ambulance: Procedure Codes

(A) For one-way emergency ambulance services, use Procedure Code 168510.

(B) For one-way non-emergency ambulance services, use Procedure Code 168512.

(C) For round-trip non-emergency ambulance services, use Procedure Code 168513.

(D) For two persons transported together, use Procedure Code 168514.

(E) For mileage per loaded mile after 20 miles each way, use Procedure Code 168515.

476.080 Other Licensed Carriers: Type of Service

A licensed carrier may be a bus, train, airplane, or boat.

476.081 Other Licensed Carriers: Criteria for Use

The Department will pay for services furnished by a licensed carrier in the following circumstances:

(A) when there is no transportation provider in the recipient's locality or it is less expensive to use a licensed carrier (e.g., train) than a transportation provider;

(B) when the recipient is traveling to specialized medical care that is a great distance from home and has obtained approval from the Assistant Director for Consultation Services, the Medical Director, and the Transportation Program Director of the Medical Division; and

(C) when a person lives on an island accessible only by boat or airplane.

476.082 Other Licensed Carriers: Authorization Requirement

(A) All airplane transportation requires prior authorization from the Medical Division (Central Office).

(B) All train, boat, or bus transportation requires prior authorization from the recipient's local Welfare Service Office or Community Service Area Office if the vendor-payment method can be used. If the licensed carrier is not a provider in the Medical Assistance Program, the recipient may pay for services directly and request reimbursement as set forth in Section 476.030.

(C) If the recipient is traveling outside his locality, documentation from a physician is required to verify that the necessary medical services can not be obtained locally.

476.083 Other Licensed Carriers: Consultation with Regional Medical Unit or Medical Division (Central Office)

In the following situations, persons designated by the Welfare Service Office or Community Service Area Office to be Medical Assistance transportation persons must consult with the Regional Medical Unit or the Medical Division (Central Office) as set forth in Section 476.021 before issuing prior authorization for bus, train, and boat transportation in the following situations:

(A) when the recipient is traveling outside his locality to obtain medical care;

(B) when there is recurring need (eight or more trips per month to the same destination for a period of two months or more); and

(C) when a recipient is traveling out of state to obtain medical care, except when the destination is a town or city within the recipient's locality.

476.084 Other Licensed Carriers: Rates of Payment

Rates of payment for licensed carriers shall be at the provider's usual and customary charge, not to exceed established legal rates if any.

476.085 Other Licensed Carriers: Procedure Codes

For train, airplane, boat, bus, or any other licensed carrier, use Procedure Code 169620.

476.086 Other Licensed Carriers: Information for Billing

Billing for licensed carriers may vary. Arrangements should be made with the Medical Division's Transportation Program.

480.008 Services by Contracted Provider

A contracted provider who undertakes the care of a recipient eligible for PGH services must provide the following services:

(A) Guidelines for Periodic Health Assessment

The Medical Division has adopted the "Guidelines for Periodic Health Assessment" (hereafter referred to as the "Guidelines") set forth in Section 480.101 of this Chapter 480. The Guidelines were developed by the Massachusetts Chapter of the American Academy of Pediatrics, in cooperation with the Medical Division, and consist of a series of simple preventive and screening procedures, arranged in "screening packages" according to the intervals or age levels at which each procedure is to be carried out. The Guidelines are designed to provide basic preventive care, and to distinguish well patients from those who require further diagnosis of suspected or actual health problems, or treatment, or both. At the initial visit, and thereafter at the intervals dictated by the Guidelines, the PGH provider must provide a health assessment, i.e., the entire screening package appropriate to the recipient in accordance with the Guidelines. A provider must not omit any procedure in a health assessment except in the rare situation where the omission is authorized for lack of medical necessity or impossibility as set forth in Section 480.009(A). In the absence of such a reason, a provider who omits any procedure in a health assessment may not bill for, or certify the de livery of, a completed health assessment. (See Section 480.011 for billing pro cedures relative to partial health assessments.)

(B) Minimal Screening Requirements

Initial and interval health histories must include an assessment for mental and emotional problems. The physical examination must include an assessment of growth, development, and nutritional status, and an examination for vision and hearing problems, anemia, sickle cell trait, lead poisoning, tuberculosis, diabetes, urinary abnormalities, and obvious physical defects. The items listed above constitute the minimum screens which must be performed directly by the PGH provider. (Hearing tests requiring the use of an audiometer, further diagnosis and treatment of vision and dental problems, and further laboratory tests may be referred to other providers.) In all cases, every screening, diagnostic, and treatment service must be performed by a person authorized by law to perform such service.

(C) Continuing Comprehensive Care

PGH providers must furnish continuing comprehensive primary medical care, including preventive services and treatment indicated by any health assessment. The Department encourages single-source comprehensive primary care, to minimize the number of instances in which referrals must be made, records transferred, and relationships between providers and PGH recipients interrupted. However,

PGH providers must make referrals consistent with sound medical practice whenever a PGH recipient requires different or more extensive diagnosis or treatment than the PGH provider can adequately and competently provide, and PGH may make referrals in other circumstances permitted by the regulations in this Chapter 480.

(D) Referrals

(1) Whenever a health assessment, a need for additional screens, or any other event prompts a PGH provider to make a referral, the PGH provider must make a reasonable effort to select an appropriate consultant and to arrange for an appointment at a date, time, and place mutually satisfactory to the recipient and the consultant. When appropriate, referrals may be made to grantees under Title V of the Social Security Act such as Children and Youth Projects and Maternal and Infant Care Programs. If the PGH provider is unable to select a consultant or to arrange an appointment, the PGH provider must request the assistance of the PGH specialist. The PGH provider must accomplish the tasks described in this section without delay and in any event in sufficient time to give reasonable assurance that the recipient will have an appointment with the consultant within 60 days after the event which prompted the referral.

(2) Whenever a PGH provider makes a referral, he must give the PGH recipient written instructions stating the following:

(a) the date on which the referral is made;

(b) the name, address, and telephone number of the referring PGH provider;

(c) the name and address of the consultant; and

(d) the date and time of the appointment, if one has been made; otherwise, a direction that an arrangement has been made for the consultant to make the appointment.

(3) Whenever a referral is made, the PGH provider must give written notice to the consultant containing the following:

(a) the information required by Subsection (D)(2) of this Section 480.008, which may be a copy of the instructions given to the recipient,

(b) the name, address, telephone number, 17-digit Medicaid identification number from the Medicaid Eligibility Card, and date of birth of the PGH recipient referred; and

(c) a brief statement indicating the reason for the referral, including any comments or instructions addressed to the consultant.

(4) Subsection 480.009(D), relative to inquiry into delivery problems, applies to referrals.

(5) The PGH Referral Form is a multi-copy form designed to facilitate compliance with this Section 480.008 and with Section 480.009 relative to monitoring and follow-up. A PGH provider that has a recordkeeping and follow-up system which it wishes to retain may submit a request for a waiver, accompanied by a detailed description of its system, to the PGH Program Director in the Medical Division. If the Program Director determines that the PGH provider's system records the same information called for by the form, and is otherwise adequate for the purposes of these regulations, he shall issue a waiver. In the absence of a waiver, the Department requires that a PGH provider use the PGH Referral Form.

480.009 Monitoring and Follow-Up

An essential element of the PGH program is the establishment of systems and procedures by which the Department will verify that PGH recipients are receiving the PGH services to which they are entitled, take corrective action when recipients are found not to be receiving those services, and acquire adequate evidence that those duties are being performed. Accordingly, PGH providers must undertake the duties set forth in this section.

(A) Certification of Health Assessment

Each claim for a complete health assessment must include a certification by the PGH provider that all of the elements of the applicable screening package have been performed. The Department recognizes that there may be a rare situation when a PGH provider might have to omit a procedure for one of the following two reasons:

(1) Omission of a Procedure Which Is Not Medically Necessary

When a PGH provider omits the performance of a procedure from a health assessment because in the provider's professional judgment there is no medical necessity to perform the procedure, the provider must state that he has omitted the procedure. He must cite the procedure and the reason for concluding that there is no medical necessity for the performance of the procedure. The statement must accompany the claim for payment, and the claim must be submitted under the appropriate code for a partial health assessment listed in Section 480.011(A).

(2) Omission of a Procedure Because of Impossibility

When a PGH provider omits the performance of a procedure from a health assessment because it is impossible to perform the procedure, the PGH provider must state that he has omitted the procedure. If the reason of impossibility is based on recipient noncompliance, the provider must report the name of the recipient to the PGH specialist. The provider must also prepare a statement describing his efforts to overcome the problem. The statement must accompany the claim for payment. The claim must be submitted under the appropriate code for a partial health assessment listed in Section 480.011(A). If a laboratory or other provider to whom a referral was made

fails to perform the procedure, the PGH provider must nevertheless ensure the performance of the procedure (e.g., by making another referral appointment with a different laboratory or other provider). The Department will disallow any claim for which the reason of impossibility is the failure of a laboratory or other referral provider to perform.

(B) Appointments with PGH Providers

When a PGH recipient fails to appear for a second or subsequent appointment with a PGH provider, the PGH provider must make attempts to arrange another appointment, by making written or telephone contacts with a responsible adult in the recipient's household. The PGH provider must record the dates, natures, and results of the efforts. If the efforts are unsuccessful, or if the recipient fails to appear for the rescheduled appointment, the PGH provider must inform the PGH specialist.

(C) Appointments with Consultants

When a referral has been made, the PGH provider must ascertain, promptly after the date of the appointment with the consultant, whether the recipient appeared for the appointment and whether treatment has been initiated. If the recipient fails to appear, the PGH provider must make attempts to arrange a second appointment, by making written or telephone contacts with a responsible adult in the recipient's household and with the consultant. The PGH provider must record the dates, natures, and results of the efforts. If the efforts are unsuccessful, or if the recipient fails to appear for the rescheduled appointment, the PGH provider must inform the PGH specialist. When the recipient keeps an appointment with a consultant, the PGH provider must obtain and record the consultant's report.

(D) Inquiry into Delivery Problems

PGH providers must determine, by inquiry, whether PGH recipients are hindered in obtaining PGH services because of a need for translation, transportation, child care, or counseling, or because of any other circumstances or conditions which may impede the delivery of PGH services. PGH providers must promptly notify the PGH specialist of any such circumstances or conditions and must urge the recipient to request the assistance of the PGH specialist. Notification to the PGH specialist may be made by completing and mailing the appropriate section of the PGH Referral Form or by telephone. Notification by telephone must be noted in the recipient's record.

(E) Medical and Other Records

A PGH provider must create and maintain a centralized record for every PGH recipient whose care he undertakes. The record must contain not only the date, nature, and extent of services furnished directly or by referral, in accordance with applicable Medical Assistance Program regulations governing medical records generally, but also the efforts of the PGH provider to comply with the provisions of this Chapter 480, including those relative to appointments, referrals, and billing.

480.010 PGH Specialists

PGH specialists are located in the Department's Community Service Area Offices (CSAOs). Each PGH specialist works under the immediate administrative supervision of the director of the CSAO in which he is located. All work under the program supervision of the PGH program in the Medical Division. The duties of PGH specialists include the following:

(A) Outreach

PGH specialists supplement the efforts of Assistance Payments and Social Services workers to explain the PGH program and its advantages to eligible persons who are not yet committed to the program and to encourage maximum utilization of the program by all eligible members of recipients' households (see the Massachusetts Public Assistance Policy Manual, Chapter II, Section A; the Assistance Payments Manual (6 CHSR III), Subchapter A, Section 303.44; and the Social Services Policy Manual, 106 CMR 282).

(B) Assistance

PGH specialists assist those recipients who need or request further outreach and information to choose and make appointments with PGH providers (whenever possible) and to overcome barriers which hinder recipients from receiving satisfactory and comprehensive health care. The PGH specialists also identify eligible individuals who are in need of those health services provided under the authority of Title V of the Social Security Act, inform said eligible persons about the services, and make referrals whenever appropriate (see the Massachusetts Public Assistance Policy Manual, Chapter II, Section A; the Assistance Payments Manual (6 CHSR III), Subchapter A, Section 303.45; and the Social Services Policy Manual, 106 CMR 282).

(C) Liaison

PGH specialists maintain liaison between the Medical Division and local health care providers. Their duties include promotion of provider participation, provision of assistance to providers, and the development of provider alternatives.

(D) Follow-Up

PGH specialists must follow-up in all cases in which a recipient has received assistance from Department staff to obtain health care services in order to ensure that services were received within a prescribed time period.

(E) Documentation

PGH specialists create and maintain records designed to identify the status of recipients in the PGH program.

Trans. by MA Letter 193

Procedure Code	Procedure Description	Allowable Fee
9043	Health assessment performed, further diagnosis or treatment indicated for hearing problem	$20.00
9063	Partial health assessment performed, further diagnosis or treatment indicated for hearing problem	I.C.*
9044	Health assessment performed, further diagnosis or treatment indicated for lead poisoning problem	20.00
9064	Partial health assessment performed, further diagnosis or treatment indicated for lead poisoning problem	I.C.*
9045	Health assessment performed, further diagnosis or treatment indicated for two or more of the problems specified for Procedure Codes 9040 through 9044 or for an unspecified problem or problems	20.00
9065	Partial health assessment performed, further diagnosis or treatment indicated for two or more of the problems specified for Procedure Codes 9040 through 9044 or for an unspecified problem or problems	I.C.*

*Individual consideration

(B) Fees for Partial Health Assessments

The Department will review individually all claims and certifications for partial health assessments based on the omission of a procedure that is either not medically necessary or impossible to perform, and will grant or deny these claims based on whether the Department agrees that there was no medical necessity or that it was impossible to perform the procedure. Review of all claims for partial health assessments based on the omission of a procedure that is not medically necessary will be performed by a physician. If the Department denies a certification of no medical necessity or impossibility, the claim will be disallowed unless the PGH provider performs or arranges for the performance of the procedure that had previously been omitted. The Department will notify the provider in all such instances. If a claim has been disallowed, the Department will notify the provider in a time limit not to exceed seven days from the date of denial. The provider can not submit, and the Department will not allow, another claim for the same service submitted under any of the office codes.

(C) Fees for Laboratory Procedures

The following laboratory services, which are included in the Guidelines, are reimbursable in addition to the health assessment services, even when furnished by the same provider who furnished the health assessment.

Service Code	Procedure Description	Allowable Fee
101126	Hematocrit	$2.00
101156	Hemoglobin, Qual. (any fluid)	2.00
101347	Urinary (blood, ketones, protein, glucose, pH) dip stick	1.00
101161	Urinalysis, routine	4.00
101019	Cultures (routine)	5.00*
101137	Sickle cell prep.	6.00
101099	Mailing blood lead specimen	1.00**
101012	Hinton test (syphilis serology)	5.00
101341	Triglycerides	10.00
101233	Cholesterol, total	5.00
101402	Pap smear (vaginal and cervical smears)	6.00

(D) Other Reimbursable Procedures

The following service, which is included in the Guidelines, is reimbursable in addition to the health assessment and laboratory services, even when furnished by the same provider who furnished the health asssessment.

Procedure Code	Procedure Description	Allowable Fee
9350	Hearing test by audiometer	$5.00

*When billing for a GC culture, use this service code

**Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

480.101 "Guidelines for Periodic Health Assessment" of the Massachusetts Chapter of the American Academy of Pediatrics

These guidelines were developed by the Massachusetts Chapter of the American Academy of Pediatrics, and are believed to reflect the prevailing standards of Massachusetts pediatricians for the necessary elements of an early and periodic screening and diagnosis program for infants, children, adolescents, and young adults. In those cases in which a recipient has had infrequent health assessment examinations, the PGH provider will provide the additional tests and screens necessary to bring the recipient up to date with his preventive health care according to the Guidelines.

Note 1: A provider must not omit any procedure in a health assessment except in the rare situation where the omission is authorized for lack of medical necessity or impossibility as set forth in Section 480.009(A). In the absence of such a reason, a provider who omits any procedure in a health assessment may not bill for, or certify the delivery of, a completed health assessment.

Note 2: The authority of the Department under M.G.L. c. 118D sec. 4 to formulate standards and criteria for the Medical Assistance Program expressly excludes "medical standards and criteria". These Guidelines are not intended to and do not establish a standard of care for purposes of tort liability. If the Massachusetts Chapter of the American Academy of Pediatrics amends these Guidelines, the Department will send the amendments to contracted providers.

Age	Service - Laboratory
2-6 weeks	a. Health history to include health of family, pregnancy delivery, and neonatal period b. Assessment of physical growth and development[1] c. Physical examination d. Appropriate immunizations[2] e. Hearing test (gross)
8-10 weeks	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)
4 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)

[1]Developmental assessment including examinations of eye/hand coordination, gross motor function, motor skills, speech development, behavior development, and assessment of nutritional status

[2]Immunizations according to the recommendations of the American Academy of Pediatrics and the Massachusetts Department of Public Health

Age	Service	Laboratory
6 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	
9 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Hematocrit or Hemoglobin b. Sickle cell test[3]
1 year	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Hematocrit or Hemoglobin (if not done at 9 months) b. TB test c. Blood lead[4]

[3]Sickle cell test only once if indicated by ethnicity. Where possible, it is advisable to perform G6PD examinations on appropriate patients at the same time as the sickle cell test

[4]The Massachusetts Department of Public Health recommends that children be tested for lead poisoning twice yearly between the ages of one and three years, and yearly between the ages of three and six years

Age	Service	Laboratory
3 years	a. Interval history b. Assessment of physical growth and development c. Physical examination[5] d. Appropriate immunizations e. Hearing test (gross) f. Vision exam (if possible)[6] g. Dental examination (if possible)[7]	a. Hematocrit or Hemoglobin b. Blood lead c. Urinalysis (and culture for girls) d. TB test
4 years	a. Interval history b. Assessment of physical growth and development c. Physical examination[8] d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer[9] g. Dental examination	a. Hematocrit or Hemoglobin b. Blood lead c. TB test d. Urinalysis (and culture for girls)

[5]Routine physical examination should include blood pressure at age of three years and onwards

[6]Vision exam if satisfactory at the age of three years should be repeated every three years

[7]Dental examination and referral to a dentist for routine care

[8]Fundoscopic examination of the eye should begin at the age of four years and should continue thereafter as part of the physical examination

[9]Hearing test by audiometer if satisfactory at the age of four years should be repeated every three years

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Age	Service	Laboratory
5 years	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Blood lead c. Urinalysis d. TB test e. Cholesterol[10]
6 years	a. Interval history b. Assessment of physical growth[11] c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Blood lead c. Urinalysis d. TB test
7 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test

[10]Cholesterol studies performed for children with family histories of heart attack, stroke, or kidney disease, and elevated lipid levels

[11]To include assessment of behavior and nutritional status

Age	Service	Laboratory
11 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Assessment of mental health	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test[12]
12 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling[13] i. Assessment of mental health	a. Hematocrit or Hemoglobin b. Urinalysis (and culture for girls)

[12]TB test should be repeated every two to three years depending on locale. Patients living in the inner city should be tested more frequently

[13]Introduction to health education and counseling to include growth and development, tobacco and drugs, sexuality, accidents, role in the family, religion, automobiles, diet, school, and so forth

Age	Service	Laboratory
13 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health	a. Hematocrit (female) b. Urinalysis
14 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination[14]	a. Hematocrit (female) b. GC culture[14] c. Pap test and culture[14] d. Serology[14] e. Urinalysis

[14]Pelvic examination and serological test to detect syphilis in females and males, respectively, who are sexually active or who are 18 years or older: GC cultures should be performed annually for patients who are sexually active or who are 18 years or older

480.008 Services by Contracted Provider

A contracted provider who undertakes the care of a recipient eligible for PGH services must provide the following services:

(A) Health Assessments

The Medical Division has adopted the Guidelines for Periodic Health Assessment (hereafter referred to as the "Guidelines") set forth in Section 480.101 of this Chapter 480. The Guidelines were developed by the Massachusetts Chapter of the American Academy of Pediatrics, in cooperation with the Medical Division, and consist of a series of simple preventive and screening procedures, arranged in "screening packages" according to the intervals or age levels at which each procedure is to be carried out. At the initial visit, and thereafter at the intervals dictated by the Guidelines, the PGH provider must provide a health assessment, i.e., the entire screening package appropriate to the recipient in accordance with the Guidelines. For PGH purposes, initial and interval health histories must include an assessment for mental and emotional problems. The physical examination must include an assessment of growth, development, and nutritional status, and an examination for vision and hearing problems, anemia, sickle cell trait, lead poisoning, tuberculosis, diabetes, urinary abnormalities, and obvious physical defects. The items listed above constitute the minimum screens which must be performed directly by the PGH provider. (Hearing tests requiring the use of an audiometer, further diagnosis and treatment of vision and dental problems, and further laboratory tests may be referred to other providers.) In all cases, every screening, diagnostic, and treatment service must be performed by a person authorized by law to perform such service. The Guidelines are designed to provide basic preventive care, and to distinguish well patients from those who require further diagnosis of suspected or actual health problems, or treatment, or both. In the context of PGH, however, the Guidelines have an additional function. They are used by the Department to ensure that participating recipients receive all of the screening procedures which the Department is legally bound to provide. For that reason, a provider must not omit any procedure in a health assessment unless, in his medical judgment, there is a compelling reason for the omission. In the absence of such a reason, a provider who omits any procedure in a health assessment may not bill for, or certify the delivery of, a completed health assessment. (See Section 480.011 for billing procedures relative to partial health assessments.)

(B) Continuing Comprehensive Care

PGH providers must furnish continuing comprehensive primary medical care, including preventive services and treatment indicated by any health assessment. The Department encourages single-source comprehensive primary care, to minimize the number of instances in which referrals must be made, records transferred, and relationships between providers and PGH recipients interrupted. However, PGH providers must make referrals consistent with sound medical practice whenever a PGH recipient requires different or more extensive diagnosis or treatment than the PGH provider can adequately and competently provide, and PGH may make referrals in other circumstances permitted by the regulations in this Chapter 480.

(C) Referrals

(1) Whenever a health assessment, a need for additional screens, or any other event prompts a PGH provider to make a referral, the PGH provider must make a reasonable effort to select an appropriate consultant and to arrange for an appointment at a date, time, and place mutually satisfactory to the recipient and the consultant. When appropriate, referrals may be made to grantees under Title V of the Social Security Act such as Children and Youth Projects and Maternal and Infant Care Programs. If the PGH provider is unable to select a consultant or to arrange an appointment, the PGH provider must request the assistance of the PGH specialist. The PGH provider must accomplish the tasks described in this section without delay and in any event in sufficient time to give reasonable assurance that the recipient will have an appointment with the consultant within 60 days after the event which prompted the referral.

(2) Whenever a PGH provider makes a referral, he must give the PGH recipient written instructions stating the following:

(a) the date on which the referral is made;

(b) the name, address, and telephone number of the referring PGH provider;

(c) the name and address of the consultant; and

(d) the date and time of the appointment, if one has been made; otherwise, a direction that an arrangement has been made for the consultant to make the appointment.

(3) Whenever a referral is made, the PGH provider must give written notice to the consultant containing the following:

(a) the information required by Subsection (2) of this Section 480.008, which may be a copy of the instructions given to the recipient;

(b) the name, address, telephone number, 17-digit Medicaid identification number from the Medicaid Eligibility Card, and date of birth of the PGH recipient referred; and

(c) a brief statement indicating the reason for the referral, including any comments or instructions addressed to the consultant.

(4) Subsection 480.009(D), relative to inquiry into delivery problems, applies to referrals.

(5) The PGH Referral Form is a multi-copy form designed to facilitate compliance with this Section 480.008 and with Section 480.009 relative to monitoring and follow-up. A PGH provider that has a recordkeeping and follow-up system which it wishes to retain may submit a request for a waiver, accompanied by a detailed description of its system, to the PGH Program Director in the Medical Division. If the Program Director determines that the PGH provider's system records the same information called for by the form, and is otherwise adequate for the purposes of these regulations, he shall issue a waiver. In the absence of a waiver, the Department requires that a PGH provider use the PGH Referral Form.

480.009 Monitoring and Follow-up

An essential element of the PGH program is the establishment of systems and procedures by which the Department will verify that PGH recipients are receiving the PGH services to which they are entitled, take corrective action when recipients are found not to be receiving those services, and acquire adequate evidence that those duties are being performed. Accordingly, PGH providers must undertake the duties set forth in this section.

(A) Certification of Health Assessment

The submission of a claim for a complete health assessment constitutes a certification by the PGH provider that all of the elements of the applicable screening package have been performed. If any laboratory or other procedure has not been performed by the PGH provider, he must receive the report of the laboratory or other provider to whom a referral was made for that procedure, before billing for a complete health assessment. If the PGH provider does not receive such report within 14 days after the referral was made, he must make, and keep a record of the following efforts to secure such report. He must first contact the provider to whom the referral was made. If he learns that the recipient failed to appear for a referral appointment, he must make at least one attempt to arrange a second appointment, by making a written or telephone contact with a responsible adult in the recipient's household and with the provider to whom the referral was made. If he learns that the failure to report is due to the error or omission of the provider to whom the referral was made, he must make a reasonable effort to obtain a report. If, despite such efforts, the necessary report cannot be obtained, the PGH provider must report the matter to the PGH specialist, and may then submit a claim for a partial assessment at an adjusted fee which will be less than the fee payable for a complete health assessment.

(B) Appointments with PGH Provider

When a PGH recipient fails to appear for an appointment with a PGH provider, the PGH provider must make at least one attempt to arrange a second appointment, by making a written or telephone contact with a responsible adult in the recipient's household. The PGH provider must record the date, nature, and result of the effort. If the effort is unsuccessful, or if the recipient fails to appear for the rescheduled appointment, the PGH provider must inform the PGH specialist.

(C) Appointment with Consultants

When a referral has been made, the PGH provider must ascertain, promptly after the date of the appointment with the consultant, whether the recipient appeared for the appointment and whether treatment has been initiated. If the recipient fails to appear, the PGH provider must make at least one attempt to arrange a second appointment, by making a written or telephone contact with a responsible adult in the recipient's household and with the consultant. The PGH provider must record the date, nature, and result of the effort. If the effort is unsuccessful, or if the recipient fails to appear for the rescheduled appointment, the PGH provider must inform the PGH specialist. When the recipient keeps an appointment with a consultant, the PGH provider must obtain and record the consultant's report.

(D) Inquiry into Delivery Problems

PGH providers must determine, by inquiry, whether PGH recipients are hindered in obtaining PGH services because of a need for translation, transportation, child care, or counseling, or because of any other circumstances or conditions which may impede the delivery of PGH services. PGH providers must promptly notify the PGH specialist of any such circumstances or conditions and must urge the recipient to request the assistance of the PGH specialist. Notification to the PGH specialist may be made by completing and mailing the appropriate section of the PGH Referral Form or by telephone. Notification by telephone must be noted in the recipient's record.

(E) Medical and Other Records

A PGH provider must create and maintain a centralized record for every PGH recipient whose care he undertakes. The record must contain not only the date, nature, and extent of services furnished directly or by referral, in accordance with applicable Medical Assistance Program regulations governing medical records generally, but also the efforts of the PGH provider to comply with the provisions of this Chapter 480, including those relative to appointments, referrals, and billing.

480.010 PGH Specialists

PGH specialists are located in the Department's Community Service Area Offices (CSAOs). Each PGH specialist works under the immediate administrative supervision of the director of the CSAO in which he is located. All work under the program supervision of the PGH program in the Medical Division. The duties of PGH specialists include the following:

(A) Outreach

PGH specialists supplement the efforts of Assistance Payments and Social Services workers to explain the PGH program and its advantages to eligible persons who are not yet committed to the program and to encourage maximum utilization of the program by all eligible members of recipients' households (see the Massachusetts Public Assistance Policy Manual, Chapter II, Section A; the Assistance Payments Manual (6 CHSR III), Subchapter A, Section 303.44; and the Social Services Policy Manual, 106 CMR 282).

(B) Assistance

PGH specialists assist those recipients who need or request further outreach and information to choose and make appointments with PGH providers (whenever possible) and to overcome barriers which hinder recipients from receiving satisfactory and comprehensive health care. The PGH specialists also identify eligible individuals who are in need of those health services provided under the authority Title V of the Social Security Act, inform said eligible persons about the services, and make referrals whenever appropriate (see the Massachusetts Public Assistance Policy Manual, Chapter II, Section A; the Assistance Payments Manual (6 CHSR III), Subchapter A, Section 303.45; and the Social Services Policy Manual, 106 CMR 282).

(C) Liaison

PGH specialists maintain liaison between the Medical Division and local health care providers. Their duties include promotion of provider participation, provision of assistance to providers having problems in delivering services, and the development of provider alternatives.

(D) Follow-up

PGH specialists must follow-up in all cases in which a recipient has received assistance from Department staff to obtain health care services in order to ensure that services were received within a prescribed time period.

(E) Documentation

PGH specialists create and maintain records designed to identify the status of recipients in the PGH program.

(F) Promotion

PGH specialists promote interest in the PGH program among recipients and providers through personal contact with recipients, public interest advertising, promotional events, and contact with public and private agencies and groups.

480.011 Submission of Claims

(A) Fees for Health Assessments

The following schedule conforms to the fee schedule adopted by the Massachusetts Rate Setting Commission for health assessment services furnished by PGH providers in accordance with the Guidelines and with the regulations in this Chapter 480. Correct use of the procedure codes is essential to the proper operation of the tracking mechanisms to be established by the Department.

Procedure Code	Procedure Description	Allowable Fee
9040	Health assessment performed, no further diagnosis or treatment indicated	$20.00
9060	Partial health assessment performed, no further diagnosis or treatment indicated	I.C.*
9041	Health assessment performed, further diagnosis or treatment indicated for vision problem	20.00
9061	Partial health assessment performed, further diagnosis or treatment indicated for vision problem	I.C.*
9042	Health assessment performed, further diagnosis or treatment indicated for dental problem	20.00
9062	Partial health assessment performed, further diagnosis or treatment indicated for dental problem	I.C.*

*Individual consideration

Procedure Code	Procedure Description	Allowable Fee
9043	Health assessment performed, further diagnosis or treatment indicated for hearing problem	$20.00
9063	Partial health assessment performed, further diagnosis or treatment indicated for hearing problem	I.C.*
9044	Health assessment performed, further diagnosis or treatment indicated for lead poisoning problem	20.00
9064	Partial health assessment performed, further diagnosis or treatment indicated for lead poisoning problem	I.C.*
9045	Health assessment performed, further diagnosis or treatment indicated for two or more of the problems specified for Procedure Codes 9040 through 9044	20.00
9065	Partial health assessment performed, further diagnosis or treatment indicated for two or more of the problems specified for Procedure Codes 9040 through 9044	I.C.*

*Individual consideration

(B) Fees for Laboratory Procedures

The following laboratory services, which are included in the Guidelines, are reimbursable in addition to the health assessment services, even when furnished by the same provider who furnished the health assessment.

Service Code	Procedure Description	Allowable Fee
101051	Hematocrit	$2.00
101052	Hemoglobin	2.00

Service Code	Procedure Description	Allowable Fee
101041	Urinalysis	$4.00
101019	Culture (routine)	5.00
101100	Sickle cell test	5.00
101099	Blood lead	1.00
101012	Serological tests for syphilis	5.00
101019	GC culture	5.00
101233 or 101341	Blood cholesterol and triglycerides	10.00
101402	Pap smear or cytology	6.00

(C) Other Reimbursable Procedures

The following service, which is included in the Guidelines, is reimbursable in addition to the health assessment and laboratory services, even when furnished by the same provider who furnished the health assessment.

Procedure Code	Procedure Description	Allowable Fee
9350	Hearing test by audiometer	$5.00

480.101 "Guidelines for Periodic Health Assessment" of the Massachusetts Chapter of the American Academy of Pediatrics

These guidelines were developed by the Massachusetts Chapter of the American Academy of Pediatrics, and are believed to reflect the prevailing standards of Massachusetts pediatricians for the necessary elements of an early and periodic screening and diagnosis program for infants, children, adolescents, and young adults.

Age	Service	Laboratory
2-6 weeks	a. Health history to include health of family, pregnancy delivery, and neonatal period b. Assessment of physical growth and development[1] c. Physical examination d. Appropriate immunizations[2] e. Hearing test (gross)	
8-10 weeks	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	
4 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Sickle cell test[3]

[1]Developmental assessment including examinations of eye/hand coordination, gross motor function, motor skills, speech development, behavior development, and assessment of nutritional status

[2]Immunizations according to the recommendations of the American Academy of Pediatrics and the Massachusetts Department of Public Health

[3]Sickle cell test only once if indicated by ethnicity. Where possible, it is advisable to perform G.6.P.D. examinations on appropriate patients at the same time as the sickle cell test

Age	Service	Laboratory
6 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	
9 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Hematocrit or Hemoglobin
1 year	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Hematocrit or Hemoglobin (if not done at 9 months) b. TB test c. Blood lead[4]

[4]The Massachusetts Department of Public Health recommends that children be tested for lead poisoning twice yearly between the ages of one and three years, and yearly between the ages of three and six years

Age	Service	Laboratory
15 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Lab tests if not previously performed
20 months	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Blood lead
2 years	a. Interval history b. Assessment of physical growth and development c. Physical examination d. Appropriate immunizations e. Hearing test (gross)	a. Hematocrit or Hemoglobin b. Blood lead c. TB test

Age	Service	Laboratory
3 years	a. Interval history b. Assessment of physical growth and development c. Physical examination[5] d. Appropriate immunizations e. Hearing test (gross) f. Vision exam (if possible)[6] g. Dental examination (if possible)[7]	a. Hematocrit or Hemoglobin b. Blood lead c. Urinalysis (and culture for girls) d. TB test
4 years	a. Interval history b. Assessment of physical growth c. Physical examination[8] d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer[9] g. Dental examination	a. Hematocrit or Hemoglobin b. Blood lead c. TB test d. Urinalysis (and culture for girls)

[5]Routine physical examination should include blood pressure at age of three years and onwards

[6]Vision exam if satisfactory at the age of three years should be repeated every three years

[7]Dental examination and referral to a dentist for routine care

[8]Fundoscopic examination of the eye should begin at the age of four years and should continue thereafter as part of the physical examination

[9]Hearing test by audiometer if satisfactory at the age of four years should be repeated every three years

Age	Service	Laboratory
5 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test d. Cholesterol[10]
6 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test
7 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test

[10]Cholesterol studies performed for children with family histories of heart attack, stroke, or kidney disease, and elevated lipid levels

Age	Service	Laboratory
8 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test
9 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test
10 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Assessment of mental health	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test d. Cholesterol

Age	Service	Laboratory
11 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Assessment of mental health	a. Hematocrit or Hemoglobin b. Urinalysis c. TB test
12 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling[11] i. Assessment of mental health	a. Hematocrit or Hemoglobin b. Urinalysis (and culture for girls)

[11]Introduction to health education and counseling to include growth and development, tobacco and drugs, sexuality, accidents, role in the family, religion, automobiles, diet, school, and so forth

Age	Service	Laboratory
13 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health	a. Hematocrit (female) b. Urinalysis
14 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination[12]	a. Hematocrit (female) b. GC culture[12] c. Pap test and culture[12] d. Serology[12] e. Urinalysis

[12]Pelvic examination, serological test for syphilis and GC cultures should be performed annually for patients who are sexually active or who are 18 years or older

Age	Service	Laboratory
15 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination	a. Hematocrit (female) b. GC culture c. Pap test and culture d. Serology e. Urinalysis
16 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination	a. Hematocrit (female) b. GC culture c. Pap test and culture d. Serology e. Urinalysis

Age	Service	Laboratory
17 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination	a. Hematocrit (female) b. GC culture c. Pap test and culture d. Serology e. Urinalysis
18 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination	a. Hematocrit (female) b. GC culture c. Pap test and culture d. Serology e. Urinalysis f. Cholesterol

Age	Service	Laboratory
19 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination	a. Hematocrit (female) b. GC culture c. Pap test and culture d. Serology e. Urinalysis
20 years	a. Interval history b. Assessment of physical growth c. Physical examination d. Immunizations (if needed) e. Vision exam (if not done before) f. Hearing test by audiometer g. Dental examination h. Health education and counseling i. Assessment of mental health j. Pelvic examination	a. Hematocrit (female) b. GC culture c. Pap test and culture d. Serology e. Urinalysis

480.101 "Guidelines for Periodic Health Assessment" of the Massachusetts Chapter of the American Academy of Pediatrics

These guidelines were developed by the Massachusetts Chapter of the American Academy of Pediatrics, and are believed to reflect the prevailing standards of Massachusetts pediatricians for the necessary elements of an early and periodic screening and diagnosis program for infants, children, adolescents, and young adults.

Age	Service	Lab
2 - 6 weeks	a. Health history to include health of family, pregnancy delivery, and neonatal period	
	b. Assessment of physical growth and development[1]	
	c. Physical examination	
	d. Appropriate immunization[2]	
	e. Hearing test (gross)	
8-10 weeks	a. Interval history	
	b. Assessment of physical growth and development	
	c. Physical examination	
	d. Appropriate immunizations	
	e. Hearing test (gross)	
4 months	a. Interval history	Sickle Cell Test[3]
	b. Assessment of physical growth and development	
	c. Physical examination	
	d. Appropriate immunizations	
	e. Hearing test (gross)	

[1] Developmental assessment including examinations of eye/hand coordination, gross motor function, motor skills, speech development, behavior development.

[2] Immunizations according to the recommendations of the American Academy of Pediatrics and the Massachusetts Department of Public Health.

[3] Sickle test only once if indicated by ethnicity. Where possible it is advisable to perform G.6.P.D. examinations on appropriate patients at the same time as the sickle test.

Age	Service	Lab
6 months	a. Interval history	
	b. Assessment of physical growth and development	
	c. Physical examination	
	d. Appropriate immunizations	
	e. Hearing test (gross)	
9 months	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth and development	
	c. Physical examination	
	d. Appropriate immunizations	
	e. Hearing test (gross)	
1 year	a. Interval history	Hematocrit or Hb. (if not done at 9 months)
	b. Assessment of physical growth and development	TB test
	c. Physical examination	
	d. Appropriate immunizations	
	e. Hearing test (gross)	Blood lead[4]
15 months	a. Interval history	Lab tests if not previously performed
	b. Assessment of physical growth and development	
	c. Physical examination	
	d. Appropriate immunizations	
	e. Hearing test (gross)	

[4] The Massachusetts Department of Public Health recommends that children be tested for lead poisoning twice yearly between the ages of one (1) and three (3), and yearly between the ages of three (3) and six (6).

Age	Service	Lab
20 months	a. Interval history	Blood lead
	b. Assessment of physical growth and development	
	c. Physical examination	
	d. Appropriate immunizations	
	e. Hearing test (gross)	
2 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth and development	Blood lead
	c. Physical examination	TB test
	d. Appropriate immunizations	
	e. Hearing test (gross)	
3 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth and development	Blood lead
	c. Physical examination[5]	Urinalysis (and culture for girls)
	d. Appropriate immunizations	TB test
	e. Hearing test (gross)	
	f. Vision exam (if possible)[6]	
	g. Dental examination (if possible)[7]	

[5] Routine physical examination should include blood pressure at age of three (3) and onwards.

[6] Vision test if satisfactory at age 3 should be repeated every three (3) years.

[7] Dental examination and referral to a dentist for routine care.

Age	Service	Lab
4 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Blood lead
	c. Physical examination	TB test
	d. Immunization if needed	Urinalysis (and culture for girls)
	e. Vision, if not done before	
	f. Hearing test by audiometer [8]	
	g. Dental examination	
5 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	TB test
	d. Immunization if needed	Cholesterol[9]
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	
6 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	TB test
	d. Immunization if needed	
	e. Vision, if not done before.	
	f. Hearing test by audiometer	
	g. Dental examination	

[8] Hearing test by audiometer if satisfactory at age four (4) should be repeated every three (3) years.

[9] Cholesterol studies performed for children with family histories of heart attack, stroke, or kidney disease, and elevated lipid levels.

Age	Service	Lab
7 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	TB test
	d. Immunization if needed	
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	
8 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	TB test
	d. Immunization if needed	
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	
9 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	TB test
	d. Immunization if needed	
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	

Age	Service	Lab
10 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	TB test
	d. Immunization if needed	Cholesterol
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	
11 years	a. Interval history	Hematocrit or Hb.
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	TB test
	d. Immunization if needed	
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	
12 years	a. Interval history	Hct or Hb.
	b. Assessment of physical growth	Urinalysis (and culture for girls)
	c. Physical examination	
	d. Immunization if needed	
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	
	h. Health education and counselling [10]	
	i. Assessment of mental health	

[10] Introduction to health education and coulselling to include growth and development, tobacco and drugs, sexuality, accidents, role in the family, religion, automobiles, diet, school, etc.

Age	Service	Lab
13 years	a. Interval history	Hct (female)
	b. Assessment of physical growth	Urinalysis
	c. Physical examination	
	d. Immunization if needed	
	e. Vision, if not done before	
	f. Hearing test by audiometer	
	g. Dental examination	
	h. Health education and counselling	
	i. Assessment of mental health	
14 years	a. Interval history	Hct (female)
	b. Assessment of physical growth	GC Smear[11]
	c. Physical examination	PAP test & culture[11]
	d. Immunization if needed	Serology[11]
	e. Vision, if not done before	Urinalysis
	f. Hearing test by audiometer	
	g. Dental examination	
	h. Health education and counselling	
	i. Assessment of mental health	
	j. Pelvic exam[11]	

[11] Pelvic exam, serological test for Syphilis and GC cultures should be performed annually in sexually active patients, or who are 18 years or older.

Age	Service	Lab
15 years	a. Interval history	Hct (female)
	b. Assessment of physical growth	GC Smear
	c. Physical examination	PAP test & culture
	d. Immunization if needed	Serology
	e. Vision, if not done before	Urinalysis
	f. Hearing test by audiometer	
	g. Dental examination	
	h. Health education and counselling	
	i. Assessment of mental health	
	j. Pelvic exam	
16 years	a. Interval history	Serology
	b. Assessment of physical growth	GC Smear
	c. Physical examination	PAP test & culture
	d. Immunization if needed	Hct (females)
	e. Vision, if not done before	Urinalysis
	f. Hearing test by audiometer	
	g. Dental examination	
	h. Health education and counselling	
	i. Assessment of mental health	
	j. Pelvic exam	
17 years	a. Interval history	Serology
	b. Assessment of physical growth	GC Smear
	c. Physical examination	PAP test & culture
	d. Immunization if needed	Hct (female)
	e. Vision, if not done before	Urinalysis
	f. Hearing test by audiometer	
	g. Dental examination	Trans. by MA Letter 177
	h. Health education and counselling	

	i. Assessment of mental health	
	j. Pelvic exam	
18 years	a. Interval history	Serology
	b. Assessment of physical growth	GC Smear
	c. Physical examination	PAP test & culture
	d. Immunization if needed	Hct (females)
	e. Vision, if not done before	Urinalysis
	f. Hearing test by audiometer	Cholesterol
	g. Dental examination	
	h. Health education and counselling	
	i. Assessment of mental health	
	j. Pelvic exam	
19 years	a. Interval history	Serology
	b. Assessment of physical growth	GC Smear
	c. Physical examination	PAP test & culture
	d. Immunization if needed	Hct (females)
	e. Vision, if not done before	Urinalysis
	f. Hearing test by audiometer	
	g. Dental examination	
	h. Health education and counselling	
	i. Assessment of mental health	
	j. Pelvic exam	

Age	Service	Lab
20 years	a. Interval history	Serology
	b. Assessment of physical growth	GC Smear
	c. Physical examination	PAP test & culture
	d. Immunization if needed	Hct. (females)
	e. Vision, if not done before	Urinalysis
	f. Hearing test by audiometer	
	g. Dental examination	
	h. Health education and counselling	
	i. Assessment of mental health	
	j. Pelvic exam	

MEDICAL ASSISTANCE PROGRAM
ABORTION SERVICES

Chapter 484.000

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484.001 Definition of Payable Abortions

(A) The Department does not pay for abortion services provided for General Relief recipients (category of assistance 04).

(B) The Department will pay for abortion services provided to Medical Assistance recipients if all of the following conditions are met:

(1) the abortion is a medically necessary abortion, or the abortion is performed upon a victim of rape or incest when such rape or incest has been reported to a law enforcement agency or public health service within 60 days of the incident; and

(2) the abortion is performed in accordance with M.G.L. c. 112, s. 12K through 12U; and

(3) the abortion claim is made in accordance with this Chapter 484.000.

(C) For the purposes of this Chapter 484.000, a medically necessary abortion is one which, according to the medical judgment of a licensed physician, is necessary in light of all factors affecting the woman's health.

(D) Unless otherwise indicated, all abortions referred to in this Chapter 484.000 are payable abortions as defined in subsections (A),(B) and (C) above.

484.002 Assurance of Recipient Rights

No provider shall use any form of coercion in the provision of abortion services. Neither the Department nor any provider, nor any agent or employee of a provider, shall mislead any recipient into believing that a decision to have or not to have an abortion will adversely affect her entitlement to benefits or services for which she would otherwise be eligible. The Department has strict requirements for confidentiality of patient records for abortion services as well as for all other medical services payable under the Program.

484.003 Participation by Department Staff

Any employee or agent of the Department who objects on moral or religious grounds to participation in the furnishing of information or other assistance concerning abortion services to recipients, and who reports such objection to his superiors, shall not be required to participate in such activities. The refusal thereafter of such person to participate in such activities shall not form the basis for any disciplinary or recriminatory action against such person.

484.004 Definition of Trimesters

(A) The length of a normal pregnancy may be divided into three parts, referred to as trimesters. If the pregnancy has existed for less than 12 weeks, the pregnancy is in its first trimester. If the pregnancy has existed for 12 or more weeks, but less than 24 weeks, the pregnancy is in its second trimester. If the pregnancy has existed for 24 or more weeks, the pregnancy is in its third trimester.

(B) For the purposes of these regulations, the elapsed period of gestation shall be calculated in accordance with regulations of the Massachusetts Department of Public Health presently or hereafter in force.

484.005 Locations in Which Abortions May Be Performed

In accordance with M.G.L. c. 112, s. 12I through 12N, inserted by Chapter 706 of the Acts of 1974, and with Massachusetts Department of Public Health rules and regulations for licensure, abortions must be performed in compliance with the following:

(A) First Trimester Abortion

A first trimester abortion must be performed by a licensed and qualified physician in a clinic licensed by the Department of Public Health to perform abortions, or in a hospital licensed by the Department of Public Health to perform abortions.

(B) Second Trimester Abortion

A second trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform abortions and to provide facilities for general surgery.

(C) Third Trimester Abortion

A third trimester abortion must be performed only to save the life of the mother or to eliminate substantial risk of grave impairment to her physical or mental health. A third trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform abortions and to provide facilities for obstetrical services.

484.006 Provider Certification Requirements

(A) Ambulatory Abortion Clinic

An ambulatory abortion clinic must be licensed by the Massachusetts Department of Public Health in compliance with the clinic licensure rules and regulations, and must comply with the "Regulations for Ambulatory Gynecological Surgery in Licensed Hospitals and Licensed Clinics" issued by the Department of Public Health. In order to receive payment from the Department, an ambulatory abortion clinic must be enrolled as a participating provider in the Medical Assistance Program. The Department will pay an ambulatory abortion clinic only for abortions performed in the first trimester.

(B) Hospital

A hospital in which abortions are performed must be licensed by the Massachusetts Department of Public Health in compliance with the hospital licensure rules and regulations, and must comply with the "Regulations for Ambulatory Gynecological Surgery in Licensed Hospitals and Licensed Clinics" issued by the Department of Public Health. In order to receive payment from the Department, a hospital must be enrolled as a participating provider in the Medical Assistance Program.

(C) Physician

In order to receive payment from the Department for abortion services, a physician must be enrolled as a participating provider in the Medical Assistance Program, and must meet one of the following requirements:

(1) be permitted to perform abortions in a hospital setting by virtue of privileges granted him as a member of the hospital medical staff or as a member of an approved residency program in obstetrics or gynecology; or

(2) be a physician who has had specialized training and has demonstrated the ability to perform such procedures.

484.007 Reimbursable Abortion-Related Services

(A) The Department will reimburse providers for the following abortion-related services when they are provided in conjunction with a payable abortion procedure:

(1) pre-operative evaluation and examination;

(2) pre-operative counseling;

(3) laboratory services, including pregnancy testing, blood type, and Rh factor;

(4) RHO(D) immune globulin (human);

(5) anesthesia (general or local);

(6) post-operative care;

(7) follow-up; and

(8) advice on contraception or referral to family planning services.

(B) Reimbursement for all of the above abortion-related services, with the exception of RHO(D) immune globulin (human), is included in the all-inclusive abortion fees for ambulatory abortion clinics, as established by the Massachusetts Rate Setting Commission. For other providers (i.e., physicians, hospitals, and outpatient departments), the Department shall make payment for any of the above abortion-related services in accordance with the fee schedule appropriate to the provider's category (see Section 484.010).

484.008 Report Requirement

(A) Completion of the Certification for Payable Abortion (CPA-2) Form

All providers (i.e., physicians, hospitals, outpatient departments, and ambulatory abortion clinics), must attach a completed Certification for Payable Abortion (CPA-2) form with each claim made to the Department for a payable abortion. To identify those abortions which meet federal reimbursement standards, specified in 42 CFR 449.100 through 449.109, the Department must secure on the CPA-2 form the certifications described in subsections (1),(2), and (3) below when applicable. For all medically necessary abortions not included in (1),(2), or (3), the certification described in subsection (4) below is required on the CPA-2 form. The provider shall indicate on the CPA-2 form which of the following circumstances is applicable, and shall complete that portion of the form with the appropriate signatures:

(1) Life of the Mother Would Be Endangered

The attending physician must certify that, in his professional judgment, the life of the mother would be endangered if the pregnancy were carried to term.

(2) Severe and Long-Lasting Damage to Mother's Physical Health

The attending physician and another physician must each certify that, in his professional judgment, severe and long-lasting damage to the

mother's physical health would result if the pregnancy were carried to term. At least one of the physicians must also certify that he is not an "interested physician", defined herein as one (a) whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or (b) who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest

The provider is responsible for submitting with the claim form signed documentation from a law enforcement agency or public health service certifying that the person upon whom the procedure was performed was a victim of rape or incest which was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services; or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from victim), and a statement that the report included the signature of the person who made the report.

(4) Other Medically Necessary Abortions

The attending physician must certify that, in his medical judgment, for reasons other than those described in subsections (1),(2), and (3) above, the abortion performed was necessary in light of all factors affecting the mother's health.

(B) Availability of Certification for Payable Abortion (CPA-2) Form

A provider may obtain a supply of the Certification for Payable Abortion (CPA-2) form from:

Medical Claims Control Center
P.O. Box 567, Dept. 38
Westboro, MA 01581

484.009 Out-of-State Abortions

(A) A facility located outside of Massachusetts is eligible to receive reimbursement for abortion services provided to Massachusetts recipients only if it is licensed by the governing or licensing agency in its state to perform abortions. An out-of-state facility must obtain a Massachusetts Medical Assistance provider number before it may receive such reimbursement from the Department.

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(B) The Department will pay for a non-emergency abortion performed in an out-of-state facility only if it is a payable abortion and if prior approval has been requested from and granted by the Department.

(1) The recipient or a referral agency may request prior approval by telephone or in writing. The request should be made to: Family Planning Program Director, Medical Division, 600 Washington Street, Room 740, Boston, MA 02111 ((617) 727-8084). The facility may also make the approval request.

(2) If the Department grants a prior approval request, it will issue a prior approval slip directly to the out-of-state facility. In order to receive payment for an out-of-state abortion which requires prior approval, the facility must attach the authorized prior approval slip to the claim form.

(3) The Department will grant a prior approval request only when the abortion service needed by the recipient is not available in a Massachusetts facility.

(C) Consistent with regulations governing other aspects of the Medical Assistance Program, the Department grants an exception to the prior approval requirement for recipients who live in communities near the borders of the states of Connecticut, New Hampshire, New York, Rhode Island, or Vermont. Such recipients may seek abortion services at facilities in these states when the location of the out-of-state facility is closer to the recipient's residence than the nearest Massachusetts abortion facility which provides equivalent services and which is eligible to participate in the Medical Assistance Program.

484.010 Reimbursement for Services

A provider of abortion services claiming reimbursement from the Department must bill according to the fee schedule appropriate to its provider category:

(A) Physicians -- Medicaid Fee Schedule for Physicians and Dentists

(B) Hospitals -- All-inclusive per diem rate for inpatient services

(C) Hospital Outpatient Departments -- Massachusetts Rate Setting Commission approved percentage-of-charge for outpatient departments

(D) Licensed Ambulatory Abortion Clinics -- Abortion Services Fee Schedule (see Section 484.101)

484.011 Billing

Refer to the Massachusetts Public Assistance Policy Manual, Chapter VII, Section A (redesignated 106 CMR 450.000) for billing regulations applicable to all providers. Providers of abortion services must bill the Department on the appropriate claim form:

(A) Physicians -- MA-7 form

(B) Hospitals -- MA-2 form

(C) Hospital Outpatient Departments -- MA-3 form

(D) Licensed Ambulatory Abortion Clinics -- MA-8 form

484.101 Fee Schedule for Licensed Ambulatory Abortion Clinics

The maximum allowable rates for abortion services payable to licensed ambulatory abortion clinics shall be either those listed below or the provider's usual fee or charge, whichever is less. The fee schedule for contraceptive supplies is in the Massachusetts Public Assistance Policy Manual, Chapter VII, Section R, Part 2 (redesignated 106 CMR 478.000).

Service Code	Procedure Description	Allowable Fee
160102	Induced Abortion -- First Trimester payable* (includes physician's charges and clinic services), CPA-2 form required**	$150.00
160103	Induced Abortion -- First Trimester payable* (clinic services only), CPA-2 form required**	75.00
160104	Spontaneous Abortion (Miscarriage) with dilation and curettage (includes physician's charges and clinic services)	I.C.***
160105	Spontaneous Abortion (Miscarriage) with dilation and curettage (clinic services only)	I.C.***
160010	RHO(D) Immune Globulin (Human)	I.C.***
160113	Induced Abortion -- First Trimester payable* (includes physician's charges and clinic services with general anesthesia), CPA-2 form required**	175.00
160114	Induced Abortion -- First Trimester payable* (clinic services and general anesthesia), CPA-2 form required**	100.00

*"Payable" as defined in Section 484.001

**All claims for payable abortions must have a completed Certification for Payable Abortion (CPA-2) form attached to the claim form (see Section 484.008)

***Individual consideration

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484.201 List of Licensed Ambulatory Abortion Clinics

All licensed ambulatory abortion clinics which are participating providers in the Medical Assistance Program are listed in alphabetical order by location.

Licensed Ambulatory Abortion Clinic	Location	Effective Date
Amherst Medical Associates	Amherst	10/1/74
Charles Circle Clinic	Boston	10/1/74
Crittenton Hastings House Clinic	Boston	10/1/74
New England Women's Service	Brookline	4/1/75
Preterm, Inc.	Brookline	10/1/74
Hampden County Obstetricians & Gynecologists, Inc.	Springfield	10/1/74

INVOICE #: _____

PROVIDER #: _____

COMMONWEALTH OF MASSACHUSETTS - DEPARTMENT OF PUBLIC WELFARE

CPA-2 FORM

CERTIFICATION FOR PAYABLE ABORTION

To the Provider:

This form must be completed and submitted with every claim made to the Department for a payable abortion, as defined in 106 CMR 484.001, performed on or after August 1, 1978.

PLEASE PRINT

To be completed in all cases:

Name of Patient: _____

Address of Patient: _____

Date of Abortion Procedure: _____

Name and City of Facility in Which Abortion Procedure Was Performed: _____

_____

Check the appropriate box below to indicate which of the following circumstances is applicable and complete that section of the form only.

---

(1) ☐ Life of the Mother Would be Endangered

I, _____, certify that on the basis of my
(print name of attending physician)

professional judgment, the life of the above-named patient would be endangered if her pregnancy were carried to term.

_____ _____

(Date of Signature) (Signature of Attending Physician)

---

(2) ☐ Severe and Long-Lasting Damage to Mother's Physical Health

Complete both (A) and (B) below.

Certification by two physicians is required.

(A) I, _____, certify that on the basis of
(Print Name of Attending Physician)

my professional judgment, severe and long-lasting physical damage to the above-named patient would result if her pregnancy were carried to term.

_____ _____

(Date of Signature) (Signature of Attending Physician)

(B) I, _____, certify that on the basis of
(Print Name of Consulting Physician)
my professional judgment, severe and long-lasting physical damage to the above-named patient would result if her pregnancy were carried to term. I also certify that I am not an "interested physician"*.

_____ _____
(Date of Signature) (Signature of Consulting Physician)

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(3) ☐ Victim of Rape or Incest

(A) I, _____, of the _____
(Print Name of Agency Authority) (Name of Law Enforcement

_____, received a signed report from _____
or Public Health Agency) (Name of Person

_____, of _____
Reporting Incident) (Address)

stating that the above-named patient was the victim of an incident of rape (or incest) which occurred on _____. The report was
(Date of Incident)

made on _____ which was within 60 days of the date on which
(Date of Report)

the incident occurred.

_____
(Signature of Law Enforcement or Public Health Agency Authority)

_____
(Date of Signature)

or (B) ☐ certification from a law enforcement or public health agency containing the above information is attached on a separate sheet.

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(4) ☐ Other Medically Necessary Abortion

I, _____, certify that on the basis of my
(Print Name of Attending Physician)
medical judgment, for reasons other than those described in (1),(2), or (3) above, the abortion performed for the above-named patient was necessary in light of all factors affecting her health.

_____ _____
(Date of Signature) (Signature of Attending Physician)

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*An "interested physician" is one: (a) whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or (b) who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

106 CMR 485.000 is amended by striking out 106 CMR 485.001 through 485.200 and inserting in place thereof the following sections:

106 CMR 485.000: MEDICAL ASSISTANCE PROGRAM STERILIZATION AND HYSTERECTOMY SERVICES

Section

485.001 Scope of This Chapter
485.002 Sterilization Services: Definitions
485.003 Sterilization Services: Reimbursable Services
485.004 Sterilization Services: Locations in Which Sterilizations May Be Performed
485.005 Sterilization Services: Informed Consent Requirements
485.006 Sterilization Services: When Informed Consent Must Be Obtained
485.007 Sterilization Services: Consent Form Requirements
485.008 Sterilization Services: Reimbursement for Services
485.009 Sterilization Services: Reimbursement for Multiple Services
485.010 Sterilization Services: Assurance of Recipient Rights
(106 CMR 485.011 through 485.049 Reserved)
485.050 Hysterectomy Services: Definition
485.051 Hysterectomy Services: Non-Reimbursable Services
485.052 Hysterectomy Services: Reimbursable Services
485.053 Hysterectomy Services: Informing the Recipient Undergoing a Hysterectomy
485.054 Hysterectomy Services: Hysterectomy Information Form
485.055 Hysterectomy Services: Reimbursement for Services
(106 CMR 485.056 through 485.100 Reserved)
485.101 Sterilization Services: Fee Schedule for Licensed Ambulatory Sterilization Clinics
(106 CMR 485.102 through 485.200 Reserved)
485.201 Sterilization Services: List of Licensed Ambulatory Sterilization Clinics

485.001: Scope of This Chapter

This Chapter 485.000, excluding Sections 485.050 through 485.055, applies to all sterilizations for which reimbursement is claimed under the Medical Assistance Program or the General Relief Medical Assistance Program. Sections 485.050 through 485.055 of this Chapter 485.000 apply to all hysterectomies for which reimbursement is claimed under these Programs.

485.002: Sterilization Services: Definitions

The following definitions apply to sterilization services:

(A) Sterilization -- any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing. A sterilization is "nontherapeutic" when the individual has chosen sterilization as a permanent method of contraception. A sterilization is "therapeutic" when it occurs as a necessary part of the treatment of an existing illness or injury, or is medically indicated and performed in conjunction with surgery upon the male or female genito-urinary tract.

(B) Mentally incompetent individual -- an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

(C) Institutionalized individual -- an individual who is:
(1) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or
(2) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

485.003: Sterilization Services: Reimbursable Services

(A) A sterilization service provided to a recipient is reimbursable only if all of the following conditions are met:
(1) the recipient has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in Sections 485.005 and 485.006, and such consent is documented in the manner described in Section 485.007;
(2) the recipient is at least 18 years old at the time consent is obtained; and

(3) the recipient is not a mentally incompetent individual or an institutionalized individual.

(B) In the case of General Relief recipients (category of assistance 04), sterilization services are reimbursable only if performed in a physician's office.

485.004: Sterilization Services: Locations in Which Sterilizations May Be Performed

(A) Male sterilization by vasectomy must be performed by a licensed physician in a physician's office, hospital, or ambulatory sterilization clinic.

(B) Female sterilization by laparoscopy must be performed by a licensed physician either in a hospital or in an ambulatory sterilization clinic. All other types of female sterilization must be performed by a licensed physician in a hospital.

(C) A hospital or ambulatory sterilization clinic in which a sterilization is performed must be licensed and in compliance with the "Regulations for Ambulatory Gynecological Surgery in Licensed Hospitals and Licensed Clinics" adopted by the Massachusetts Department of Public Health. In order to receive reimbursement from the Department, a physician, hospital, or ambulatory sterilization clinic must be a participating provider in the Medical Assistance Program.

485.005: Sterilization Services: Informed Consent Requirements

Informed consent for sterilization must be voluntarily given by the recipient in accordance with the requirements specified in this section.

(A) The person who obtains consent (e.g., physician, nurse, counselor) must provide orally all of the following information and advice to the recipient requesting sterilization:

(1) advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the individual might be otherwise entitled;

(2) a description of available alternative methods of family planning and birth control;

(3) advice that the sterilization procedure is considered to be irreversible;

(4) a thorough explanation of the specific sterilization procedure to be performed;

(5) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
(6) a full description of the benefits or advantages that may be expected as a result of the sterilization; and
(7) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in Section 485.006(A).

(B) The person who obtains consent must also:
(1) offer to answer any questions the recipient may have concerning the sterilization procedure;
(2) provide a copy of the consent form to the recipient;
(3) make suitable arrangements to ensure that the information and advice required by this section is effectively communicated to any recipient who is blind, deaf, or otherwise handicapped;
(4) provide an interpreter, if the recipient does not understand the language used on the consent form or the language used by the person obtaining consent; and
(5) allow the recipient to have a witness of his or her choice present when consent is obtained.

485.006: Sterilization Services: When Informed Consent Must Be Obtained

(A) Informed consent for sterilization must be given by the recipient at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A recipient may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(B) An exception to (A) above is allowed in the case of sterilization performed during the calendar month March 1979; in such cases, the consent may have been given as late as 72 hours prior to the sterilization, and documented by a CS-1 form.

(C) Informed consent for sterilization may not be obtained or given while the recipient requesting sterilization is:
(1) in labor or childbirth;
(2) seeking to obtain or obtaining an abortion; or
(3) under the influence of alcohol or other substances that affect the individual's state of awareness.

(D) Shortly before the performance of the sterilization procedure, the physician performing the sterilization must orally inform the recipient of all of the information and advice specified in Section 485.005(A)(1) through (6).

485.007: Sterilization Services: Consent Form Requirements

Informed consent must be documented by the completion of the Department's Consent for Sterilization form in accordance with the following requirements.

(A) Required Consent Form.

(1) One of the following Consent for Sterilization forms must be used:

(a) CS-18 (green) -- for recipients aged 18 to 21; or

(b) CS-21 (yellow) -- for recipients aged 21 and above.

The distinction between the two forms is made for federal-reimbursement purposes only and will not affect the processing of claims made to the Department for sterilization services.

(2) An exception to (1) above is allowed in the case of sterilizations performed during the calendar month March 1979; in such cases, the consent may have been given as late as 72 hours prior to the sterilization, and documented by a CS-1 form.

(B) Required Signatures. The Consent for Sterilization (CS-18 or CS-21) form must be signed and dated at the time of consent by the recipient, by the interpreter (if one was provided), and by the person who obtained the consent. After the sterilization procedure has been performed, the form must be signed and dated by the physician who performed the procedure.

(C) Required Submission and Distribution of the Consent Form. The Consent for Sterilization (CS-18 or CS-21) form must be completed in triplicate and distributed as follows:

(1) the copy marked "1. Patient" must be given to the recipient at the time of consent;

(2) the copy marked "2. Physician" must be included in the recipient's permanent medical record at the time of admission at the site where the sterilization is performed; and

(3) all providers must attach a copy of the completed Consent for Sterilization (CS-18 or CS-21) form with each claim made to the Department for sterilization services. The copy marked "3. State Agency, Program or Project" is for this purpose; however, when more than one provider is billing the Department (e.g., physician, anesthesiologist, hospital), photocopies of the completed consent form may be submitted in lieu of the original.

(D) Availability of Consent for Sterilization Forms. Consent for Sterilization (CS-18 or CS-21) forms may be obtained from:

Medical Claims Control Center
P.O. Box 567, Dept. 38
Westboro, MA 01581

485.008: Sterilization Services: Reimbursement for Services

Reimbursement for sterilization services may be claimed by providers in the following provider categories, using the indicated fee schedules:

(A) Physicians -- Medicaid Fee Schedule for Physicians and Dentists

(B) Hospitals -- All-inclusive per diem rate for inpatient services

(C) Hospital Outpatient Departments -- Massachusetts Rate Setting Commission approved percentage-of-charge for outpatient departments

(D) Licensed Ambulatory Sterilization Clinics -- Sterilization Services Fee Schedule (see Section 485.101)

485.009: Sterilization Services: Reimbursement for Multiple Services

A sterilization performed in conjunction with another procedure (e.g., a delivery) is reimbursable only if all of the requirements for sterilization outlined in this Chapter 485.000 are met. If two surgical procedures are performed for a recipient on the same day or during the same stay, the following procedures must be followed:

(A) physicians may not bill in excess of the total of the maximum allowable charge for the more costly procedure plus one half of the maximum allowable charge for the second surgical procedure;

(B) hospital outpatient departments must bill at the approved percentage-of-charge for outpatient departments; and

(C) hospitals must bill at the all-inclusive per diem rate for inpatient services. If a sterilization performed in conjunction with another procedure does not meet all of the requirements for sterilization outlined in this Chapter 485.000, the claim for the entire inpatient stay will be disallowed.

485.010: Sterilization Services: Assurance of Recipient Rights

No provider shall use any form of coercion in the provision of sterilization services. Neither the Department nor any provider, nor any agent or employee of a provider, shall mislead any recipient into believing that a decision to have or not to have a sterilization will adversely affect his or her entitlement to benefits or services for which he or she would otherwise be eligible. The Department has strict requirements for confidentiality of patient records for sterilization services as well as for all other medical services payable under the Medical Assistance Program.

(106 CMR 485.011 through 485.049 Reserved)

485.050: Hysterectomy Services: Definition

Hysterectomy -- a medical procedure or operation for the purpose of removing the uterus.

485.051: Hysterectomy Services: Non-Reimbursable Services

A hysterectomy service provided to a recipient is not reimbursable if:

(A) it was performed solely for the purpose of rendering the recipient permanently incapable of reproducing; or

(B) there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the recipient permanently incapable of reproducing.

485.052: Hysterectomy Services: Reimbursable Services

A hysterectomy service provided to a recipient is reimbursable only if the following conditions are met:

(A) the recipient is informed about the hysterectomy in the manner described in Section 485.053 and receipt of such information is documented in the manner described in Section 485.054; and

(B) the provider is in compliance with the Department's Consultation Program for Elective Surgery ("Second Opinion Program") regulations (Massachusetts Public Assistance Policy Manual, Chapter VII, Section C (now redesignated 106 CMR 452.000)).

485.053: Hysterectomy Services: Informing the Recipient Undergoing a Hysterectomy

The person who secures the authorization to perform the hysterectomy must inform the recipient and her representative, if any, orally and in writing, that the hysterectomy will render the recipient permanently incapable of reproducing. Delivery in hand to the recipient of the Department's Hysterectomy Information (HI-1) form will fulfill the written requirement set forth herein, but not the oral requirement.

485.054: Hysterectomy Services: Hysterectomy Information Form

(A) Before the hysterectomy operation, the recipient or her representative, if any, must sign and date the Department's Hysterectomy Information (HI-1) form as acknowledgement of receipt of the information required in Section 485.053.

(B) All providers must attach a copy of the completed Hysterectomy Information (HI-1) form with each claim made to the Department for hysterectomy services. When more than one provider is billing the Department (e.g., physician, anesthesiologist, hospital), photocopies of the signed form may be submitted in lieu of the original.

(C) The Department's Hysterectomy Information (HI-1) form may be obtained from:

Medical Claims Control Center
P.O. Box 567, Dept. 38
Westboro, MA 01581

485.055: Hysterectomy Services: Reimbursement for Services

Reimbursement for hysterectomy services may be claimed by providers in the following provider categories, using the indicated fee schedules:

(A) Physicians -- Medicaid Fee Schedule for Physicians and Dentists

(B) Hospitals -- All-inclusive per diem rate for inpatient services

(C) Hospital Outpatient Departments -- Massachusetts Rate Setting Commission approved percentage-of-charge for outpatient departments

(106 CMR 485.056 through 485.100 Reserved)

485.101: Sterilization Services: Fee Schedule for Licensed Ambulatory Sterilization Clinics

(A) The maximum allowable rates for sterilization services payable to licensed ambulatory sterilization clinics shall be either those listed below or the provider's usual fee or charge, whichever is less.

(B) Sterilization services shall include at least the following: pre-operative evaluation and counseling, laboratory services, anesthesia, and post-operative care.

(C) All claims for sterilization services must have a completed Consent for Sterilization (CS-18 or CS-21) form attached to the claim form (see Section 485.007).

Service Code	Procedure Description	Allowable Fee
160200	Transection of Fallopian Tubes by Laparoscopy, local anesthesia, non-therapeutic	$300.00
160201	Transection of Fallopian Tubes by Laparoscopy, general anesthesia, non-therapeutic	325.00
160202	Transection of Fallopian Tubes by Laparoscopy, local anesthesia, therapeutic	300.00
160203	Transection of Fallopian Tubes by Laparoscopy, general anesthesia, therapeutic	325.00
160204	Vasectomy or Ligation of Vas, local anesthesia, non-therapeutic	110.00
160205	Vasectomy or Ligation of Vas, general anesthesia, non-therapeutic	135.00
160206	Vasectomy or Ligation of Vas, local anesthesia, therapeutic	110.00
160207	Vasectomy or Ligation of Vas, general anesthesia, therapeutic	135.00

(106 CMR 485.102 through 485.200 Reserved)

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485.201: Sterilization Services: List of Licensed Ambulatory Sterilization Clinics

All licensed ambulatory sterilization clinics providing sterilization services are listed in alphabetical order by location.

Licensed Ambulatory Sterilization Clinics	Location	Type of Service	Effective Date
Charles Circle Clinic	Boston	Tubal Ligation Vasectomy	3/1/76
Crittenton Hastings House Clinic	Boston	Vasectomy	3/1/76
Boston Family Planning Project U.S. Public Health Hospital	Brighton	Vasectomy	3/1/76
Health Care of Southeastern Mass. Brockton Family Planning Clinic	Brockton	Vasectomy	3/1/76
Preterm, Inc.	Brookline	Tubal Ligation Vasectomy	3/1/76
Hampden County Obstetricians and Gynecologists, Inc.	Springfield	Tubal Ligation	3/1/76

REGULATORY AUTHORITY

106 CMR 485.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

ACME
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CAMBRIDGE STREET
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